

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: 14-2011	Period: From 01/01/2018 To 06/30/2018	Worksheet S Parts I-III Date/Time Prepared: 11/28/2018 1:37 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: 11/28/2018 Time: 1:37 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HOLY FAMILY MEDICAL CENTER (14-2011) for the cost reporting period beginning 01/01/2018 and ending 06/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) ROBERT ROSENBERGER
Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER
Title

(Dated when report is electronically signed.)
Date

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	43,902	3,233	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0	0	0		0	6.00
200.00 Total	0	43,902	3,233	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-2011		Period: From 01/01/2018 To 06/30/2018		Worksheet S-2 Part I Date/Time Prepared: 11/28/2018 1:32 pm						
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 100 NORTH RIVER ROAD, SECOND FLOOR		PO Box:						1.00			
2.00	City: DES PLAINES		State: IL		Zip Code: 60016		County: COOK		2.00			
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)					
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00			
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		HOLY FAMILY MEDICAL CENTER	142011	16974	2	03/01/2006	N	P	P	3.00	
4.00	Subprovider - IPF										4.00	
5.00	Subprovider - IRF										5.00	
6.00	Subprovider - (Other)										6.00	
7.00	Swing Beds - SNF										7.00	
8.00	Swing Beds - NF										8.00	
9.00	Hospital-Based SNF										9.00	
10.00	Hospital-Based NF										10.00	
11.00	Hospital-Based OLTC										11.00	
12.00	Hospital-Based HHA										12.00	
13.00	Separately Certified ASC										13.00	
14.00	Hospital-Based Hospice										14.00	
15.00	Hospital-Based Health Clinic - RHC										15.00	
16.00	Hospital-Based Health Clinic - FQHC										16.00	
17.00	Hospital-Based (CMHC) I										17.00	
18.00	Renal Dialysis										18.00	
19.00	Other										19.00	
						From:	To:					
						1.00	2.00					
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2018	06/30/2018		20.00			
21.00	Type of Control (see instructions)					1			21.00			
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		22.00			
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		22.01			
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02			
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		22.03			
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						0		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.					0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.					0	0	0	0	0	0	25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-2011	Period: From 01/01/2018 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/28/2018 1:32 pm			
		Urban/Rural	St	Date of Geogra			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1					26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1					27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0					35.00
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.						36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0					37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)						37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.						38.00
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N				39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N				40.00
		V	XVIII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	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
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	Y					56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N					58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N					59.00
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	N					60.00
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03

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

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

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			1.00	
Long Term Care Hospital PPS				
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		Y	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N	81.00
TEFRA Providers				
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87.00
			V 1.00	XIX 2.00
Title V and XIX Services				
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
Rural Providers				
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00
			Physical 1.00	Occupational 2.00
			Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N		109.00
			1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.		N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-2011	Period: From 01/01/2018 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/28/2018 1:32 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.	2			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	677,868	118.01
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y		5.06	122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		14H082	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-2011		Period: From 01/01/2018 To 06/30/2018		Worksheet S-2 Part I Date/Time Prepared: 11/28/2018 1:32 pm		
1.00		2.00		3.00				
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.								
141.00	Name: PRESENCE HEALTH	Contractor's Name: NGS		Contractor's Number: 00131		141.00		
142.00	Street: 200 S. WACKER DRIVE	PO Box:		Zip Code: 60606		142.00		
143.00	City: CHI CAGO	State: IL		143.00				
							1.00	
144.00	Are provider based physicians' costs included in Worksheet A?						Y	144.00
							1.00	
							2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.						Y	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.						N	146.00
							1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N	149.00
		Part A	Part B	Title V	Title XIX			
		1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital	N	N	N	N			155.00
156.00	Subprovider - IPF	N	N	N	N			156.00
157.00	Subprovider - IRF	N	N	N	N			157.00
158.00	SUBPROVIDER							158.00
159.00	SNF	N	N	N	N			159.00
160.00	HOME HEALTH AGENCY	N	N	N	N			160.00
161.00	CMHC		N	N	N			161.00
							1.00	
165.00	Multi campus Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00
							1.00	
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.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00
							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)							170.00
							1.00	
							2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-2011		Period: From 01/01/2018 To 06/30/2018		Worksheet S-2 Part II Date/Time Prepared: 11/28/2018 1:32 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	09/12/2018			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	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			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N			14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N			15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	11/05/2018	Y	11/05/2018		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-2011	Period: From 01/01/2018 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/28/2018 1:32 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 relifed for Medicare purposes? If yes, see instructions			Y	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.			Y	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00		2.00	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICK		GILLI LAND	41.00
42.00	Enter the employer/company name of the cost report preparer	PRESENCE HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	8478133718		PATRICK.GILLI LAND@AMI TAHEALTH.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-2011	Period: From 01/01/2018 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/28/2018 1:32 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REGIONAL DIRECTOR OF REIMBURSEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-2011

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

Worksheet S-3
Part I
Date/Time Prepared:
11/28/2018 1:32 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	120	21,720	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)		120	21,720	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	1,448	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		128	23,168	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		128				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: 14-2011

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

Worksheet S-3
Part I
Date/Time Prepared:
11/28/2018 1:32 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	6,125	2,275	14,209			1.00
2.00 HMO and other (see instructions)	0	0				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)	6,125	2,275	14,209			7.00
8.00 INTENSIVE CARE UNIT	318	172	986			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)	6,443	2,447	15,195	0.24	436.52	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	18			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.24	436.52	27.00
28.00 Observation Bed Days		0	0			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	467					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-2011

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

Worksheet S-3
Part I
Date/Time Prepared:
11/28/2018 1:32 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	236	83	737	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	236	83	737	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			39			33.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 14-2011	Period: From 01/01/2018 To 06/30/2018	Worksheet A Date/Time Prepared: 11/28/2018 1:32 pm		
Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassified ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)		
	1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT		955,880	955,880	-90,355	865,525	1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		0	0	2,353,835	2,353,835	2.00
3.00 00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	29,253	-277,481	-248,228	0	-248,228	4.00
5.01 00540	NONPATIENT TELEPHONES	0	97,828	97,828	0	97,828	5.01
5.02 00550	DATA PROCESSING	0	0	0	0	0	5.02
5.03 00560	PURCHASING RECEIVING AND STORES	0	0	0	0	0	5.03
5.04 00570	ADMINITTING	0	0	0	0	0	5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.05
5.06 00590	ADMINISTRATIVE & GENERAL	2,257,647	9,403,246	11,660,893	-955,369	10,705,524	5.06
6.00 00600	MAINTENANCE & REPAIRS	184,308	201,334	385,642	-5,333	380,309	6.00
7.00 00700	OPERATION OF PLANT	197,408	1,114,739	1,312,147	-37,938	1,274,209	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	37,634	107,974	145,608	-43,196	102,412	8.00
9.00 00900	HOUSEKEEPING	399,936	280,143	680,079	-8,753	671,326	9.00
10.00 01000	DIETARY	239,597	604,917	844,514	-300,105	544,409	10.00
11.00 01100	CAFETERIA	0	0	0	294,231	294,231	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	329,058	410,927	739,985	-94,964	645,021	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	50,284	59,566	109,850	-199,559	-89,709	14.00
15.00 01500	PHARMACY	436,172	1,669,128	2,105,300	-1,551,779	553,521	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	193,046	193,046	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	5,316,165	2,219,071	7,535,236	-938,419	6,596,817	30.00
31.00 03100	INTENSIVE CARE UNIT	798,917	308,485	1,107,402	-90,496	1,016,906	31.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	532,903	732,858	1,265,761	-388,641	877,120	50.00
53.00 05300	ANESTHESIOLOGY	0	180,451	180,451	-954	179,497	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	257,110	175,047	432,157	-104,835	327,322	54.00
56.00 05600	RADIOISOTOPE	20,237	18,314	38,551	-1,380	37,171	56.00
57.00 05700	CT SCAN	41,032	18,238	59,270	-5,370	53,900	57.00
57.01 03630	ULTRA SOUND	51,886	21,569	73,455	-10,754	62,701	57.01
58.00 05800	MRI	0	188	188	-188	0	58.00
60.00 06000	LABORATORY	0	1,241,424	1,241,424	-35,510	1,205,914	60.00
65.00 06500	RESPIRATORY THERAPY	1,288,040	495,084	1,783,124	-22,192	1,760,932	65.00
66.00 06600	PHYSICAL THERAPY	1,024,143	263,522	1,287,665	-9,451	1,278,214	66.00
69.00 06900	ELECTROCARDIOLOGY	26,404	9,149	35,553	-3,400	32,153	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	94,115	34,230	128,345	-4,419	123,926	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,227,506	1,227,506	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	161,615	161,615	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,645,413	1,645,413	73.00
74.00 07400	RENAL DIALYSIS	223,707	118,152	341,859	-35,366	306,493	74.00
76.00 03950	SUBSTANCE ABUSE	150,948	33,452	184,400	265,189	449,589	76.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	302,185	558,359	860,544	-451,969	408,575	76.98
76.99 07699	LITHOTRIpsy	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	43	3,002	3,045	-2,127	918	90.00
90.02 09001	WOMENS DIAGNOSTIC CENTER	28,305	24,356	52,661	-11,790	40,871	90.02
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE		736,223	736,223	-736,223	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	14,317,437	21,819,375	36,136,812	0	36,136,812	118.00
NONREIMBURSABLE COST CENTERS							
200.00	TOTAL (SUM OF LINES 118 through 199)	14,317,437	21,819,375	36,136,812	0	36,136,812	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-2011

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

Worksheet A
Date/Time Prepared:
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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	-487,137	378,388	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	139,105	2,492,940	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	55,981	-192,247	4.00
5.01	00540	NONPATIENT TELEPHONES	0	97,828	5.01
5.02	00550	DATA PROCESSING	878,306	878,306	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	-38,813	-38,813	5.03
5.04	00570	ADMINITTING	0	0	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	872,137	872,137	5.05
5.06	00590	ADMINISTRATIVE & GENERAL	135,663	10,841,187	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	380,309	6.00
7.00	00700	OPERATION OF PLANT	0	1,274,209	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	102,412	8.00
9.00	00900	HOUSEKEEPING	0	671,326	9.00
10.00	01000	DIETARY	0	544,409	10.00
11.00	01100	CAFETERIA	-116,930	177,301	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	645,021	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	-89,709	14.00
15.00	01500	PHARMACY	0	553,521	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	281,859	281,859	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	193,046	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	6,596,817	30.00
31.00	03100	INTENSIVE CARE UNIT	71,720	1,088,626	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	877,120	50.00
53.00	05300	ANESTHESIOLOGY	-178,695	802	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	327,322	54.00
56.00	05600	RADIOISOTOPE	0	37,171	56.00
57.00	05700	CT SCAN	0	53,900	57.00
57.01	03630	ULTRA SOUND	0	62,701	57.01
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	-31,673	1,174,241	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,760,932	65.00
66.00	06600	PHYSICAL THERAPY	0	1,278,214	66.00
69.00	06900	ELECTROCARDIOLOGY	0	32,153	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	123,926	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,227,506	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	161,615	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,645,413	73.00
74.00	07400	RENAL DIALYSIS	0	306,493	74.00
76.00	03950	SUBSTANCE ABUSE	0	449,589	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	408,575	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	918	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	40,871	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,581,523	37,718,335	118.00
NONREIMBURSABLE COST CENTERS					
200.00		TOTAL (SUM OF LINES 118 through 199)	1,581,523	37,718,335	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - INTEREST					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	736,223	1.00
	TOTALS		0	736,223	
B - CAPITAL COSTS					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,160,173	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
	TOTALS		0	1,160,173	
C - RECLASS DIETARY COSTS					
1.00	CAFETERIA	11.00	83,476	210,755	1.00
	TOTALS		83,476	210,755	
D - RECLASS SUPPLY COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,227,506	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	161,615	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
	TOTALS		0	1,389,121	
E - RECLASS DRUG COSTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,645,413	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
	TOTALS		0	1,645,413	

RECLASSIFICATIONS

Provider CCN: 14-2011

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

Worksheet A-6

Date/Time Prepared:
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		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
F - RECLASS RESIDENCY COSTS					
1.00	I&R SERVICES-SALARY & FRINGES	21.00	176,677	16,369	1.00
	APPRV _____				
	TOTALS		176,677	16,369	
G - RECLASS RENTAL COSTS					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	457,439	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
	TOTALS		0	457,439	
H - RECLASS SUBSTANCE ABUSE					
1.00	SUBSTANCE ABUSE	76.00	204,228	60,973	1.00
	TOTALS		204,228	60,973	
500.00	Grand Total: Increases		464,381	5,676,466	500.00

RECLASSIFICATIONS

Provider CCN: 14-2011

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

Worksheet A-6
Date/Time Prepared:
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Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
A - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	736,223	9	1.00
	TOTALS		0	736,223		
B - CAPITAL COSTS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	90,355	11	1.00
2.00	ADMINISTRATIVE & GENERAL	5.06	0	747,113	9	2.00
3.00	MAINTENANCE & REPAIRS	6.00	0	3,176	0	3.00
4.00	OPERATION OF PLANT	7.00	0	36,843	0	4.00
5.00	HOUSEKEEPING	9.00	0	2,100	0	5.00
6.00	DIETARY	10.00	0	2,075	0	6.00
7.00	NURSING ADMINISTRATION	13.00	0	91,031	0	7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	26,645	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	20,908	0	9.00
10.00	INTENSIVE CARE UNIT	31.00	0	1,408	0	10.00
11.00	OPERATING ROOM	50.00	0	31,176	0	11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	42,450	0	12.00
13.00	ULTRA SOUND	57.01	0	10,208	0	13.00
14.00	MRI	58.00	0	188	0	14.00
15.00	LABORATORY	60.00	0	31,465	0	15.00
16.00	RESPIRATORY THERAPY	65.00	0	5,766	0	16.00
17.00	PHYSICAL THERAPY	66.00	0	2,564	0	17.00
18.00	ELECTROCARDIOLOGY	69.00	0	1,908	0	18.00
19.00	ELECTROENCEPHALOGRAPHY	70.00	0	2,910	0	19.00
20.00	RENAL DIALYSIS	74.00	0	87	0	20.00
21.00	WOMENS DIAGNOSTIC CENTER	90.02	0	9,797	0	21.00
	TOTALS		0	1,160,173		
C - RECLASS DIETARY COSTS						
1.00	DIETARY	10.00	83,476	210,755	0	1.00
	TOTALS		83,476	210,755		
D - RECLASS SUPPLY COSTS						
1.00	MAINTENANCE & REPAIRS	6.00	0	883	0	1.00
2.00	OPERATION OF PLANT	7.00	0	256	0	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	43,142	0	3.00
4.00	HOUSEKEEPING	9.00	0	5,745	0	4.00
5.00	DIETARY	10.00	0	2,460	0	5.00
6.00	NURSING ADMINISTRATION	13.00	0	2,968	0	6.00
7.00	PHARMACY	15.00	0	1,460	0	7.00
8.00	ADULTS & PEDIATRICS	30.00	0	584,284	0	8.00
9.00	INTENSIVE CARE UNIT	31.00	0	80,913	0	9.00
10.00	OPERATING ROOM	50.00	0	342,318	0	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	54,592	0	11.00
12.00	ULTRA SOUND	57.01	0	546	0	12.00
13.00	ELECTROCARDIOLOGY	69.00	0	110	0	13.00
14.00	ELECTROENCEPHALOGRAPHY	70.00	0	391	0	14.00
15.00	RENAL DIALYSIS	74.00	0	30,993	0	15.00
16.00	HYPERBARIC OXYGEN THERAPY	76.98	0	236,945	0	16.00
17.00	CLINIC	90.00	0	34	0	17.00
18.00	WOMENS DIAGNOSTIC CENTER	90.02	0	1,078	0	18.00
19.00	SUBSTANCE ABUSE	76.00	0	3	0	19.00
	TOTALS		0	1,389,121		
E - RECLASS DRUG COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.06	0	755	0	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	438	0	2.00
3.00	PHARMACY	15.00	0	1,549,502	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	55,121	0	4.00
5.00	INTENSIVE CARE UNIT	31.00	0	7,875	0	5.00
6.00	OPERATING ROOM	50.00	0	8,658	0	6.00
7.00	ANESTHESIOLOGY	53.00	0	954	0	7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,548	0	8.00
9.00	RADIOISOTOPE	56.00	0	64	0	9.00
10.00	CT SCAN	57.00	0	5,356	0	10.00
11.00	LABORATORY	60.00	0	151	0	11.00
12.00	RESPIRATORY THERAPY	65.00	0	678	0	12.00
13.00	PHYSICAL THERAPY	66.00	0	129	0	13.00
14.00	ELECTROCARDIOLOGY	69.00	0	20	0	14.00
15.00	RENAL DIALYSIS	74.00	0	4,278	0	15.00
16.00	SUBSTANCE ABUSE	76.00	0	9	0	16.00
17.00	HYPERBARIC OXYGEN THERAPY	76.98	0	5,866	0	17.00
18.00	CLINIC	90.00	0	11	0	18.00
	TOTALS		0	1,645,413		
F - RECLASS RESIDENCY COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.06	176,677	16,369	0	1.00
	TOTALS		176,677	16,369		

RECLASSIFICATIONS

Provider CCN: 14-2011

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

Worksheet A-6

Date/Time Prepared:
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Decreases							
Cost Center	Line #	Salary	Other	Wkst.	A-7 Ref.		
6.00	7.00	8.00	9.00	10.00			
G - RECLASS RENTAL COSTS							
1.00	ADMINISTRATIVE & GENERAL	5.06	0	14,455	10		1.00
2.00	MAINTENANCE & REPAIRS	6.00	0	1,274	0		2.00
3.00	OPERATION OF PLANT	7.00	0	839	0		3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	54	0		4.00
5.00	HOUSEKEEPING	9.00	0	908	0		5.00
6.00	DIETARY	10.00	0	1,339	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	965	0		7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	172,476	0		8.00
9.00	PHARMACY	15.00	0	817	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	12,905	0		10.00
11.00	INTENSIVE CARE UNIT	31.00	0	300	0		11.00
12.00	OPERATING ROOM	50.00	0	6,489	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,245	0		13.00
14.00	RADIOISOTOPE	56.00	0	1,316	0		14.00
15.00	CT SCAN	57.00	0	14	0		15.00
16.00	LABORATORY	60.00	0	3,894	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	15,748	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	6,758	0		18.00
19.00	ELECTROCARDIOLOGY	69.00	0	1,362	0		19.00
20.00	ELECTROENCEPHALOGRAPHY	70.00	0	1,118	0		20.00
21.00	RENAL DIALYSIS	74.00	0	8	0		21.00
22.00	HYPERBARIC OXYGEN THERAPY	76.98	0	209,158	0		22.00
23.00	CLINIC	90.00	0	2,082	0		23.00
24.00	WOMENS DIAGNOSTIC CENTER	90.02	0	915	0		24.00
	TOTALS		0	457,439			
H - RECLASS SUBSTANCE ABUSE							
1.00	ADULTS & PEDIATRICS	30.00	204,228	60,973	0		1.00
	TOTALS		204,228	60,973			
500.00	Grand Total: Decreases		464,381	5,676,466			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-2011

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

Worksheet A-7
Part I
Date/Time Prepared:
11/28/2018 1:32 pm

	Beginning Balances	Acquisitions			Disposals and Retirements		
		Purchases	Donation	Total			
		1.00	2.00	3.00			4.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	342,000	5,978,000	0	5,978,000	0	1.00
2.00	Land Improvements	687,067	0	0	0	289,567	2.00
3.00	Buildings and Fixtures	92,123,212	0	0	0	70,873,125	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	14,588,292	0	0	0	12,847,504	5.00
6.00	Movable Equipment	11,536,302	0	0	0	8,362,426	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	119,276,873	5,978,000	0	5,978,000	92,372,622	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	119,276,873	5,978,000	0	5,978,000	92,372,622	10.00
	Ending Balance		Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	6,320,000	0				1.00
2.00	Land Improvements	397,500	0				2.00
3.00	Buildings and Fixtures	21,250,087	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	1,740,788	0				5.00
6.00	Movable Equipment	3,173,876	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	32,882,251	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	32,882,251	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-2011

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

Worksheet A-7
Part II
Date/Time Prepared:
11/28/2018 1:32 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	955,880	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	955,880	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	955,880				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	955,880				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-2011

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

Worksheet A-7
Part III
Date/Time Prepared:
11/28/2018 1:32 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	107,740,571	0	107,740,571	0.903281	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	11,536,302	0	11,536,302	0.096719	0	2.00
3.00	Total (sum of lines 1-2)	119,276,873	0	119,276,873	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	468,743	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	875,328	457,439	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,344,071	457,439	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	-90,355	0	0	0	378,388	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,160,173	0	0	0	2,492,940	2.00
3.00	Total (sum of lines 1-2)	1,069,818	0	0	0	2,871,328	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-2011

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

Worksheet A-8

Date/Time Prepared:
11/28/2018 1:32 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 #			
			3.00	4.00			
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00	0	7.00
8.00 Television and radio service (chapter 21)			0		0.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-495,331				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	2,698,212				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-116,930	CAFETERIA		11.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts			0		0.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	A	-185,588	CAP REL COSTS-BLDG & FIXT		1.00	9	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	A	133,081	CAP REL COSTS-MVBLE EQUIP		2.00	9	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00 OFFSET SUBSTANCE ABUSE REVENUE			0		0.00	0	33.00
33.01 MISC ADMIN INCOME	B	-125,838	ADMINISTRATIVE & GENERAL		5.06	0	33.01
33.02 OTHER ADJUSTMENTS (SPECIFY) (3)			0		0.00	0	33.02

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
34.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.00
35.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	35.00
36.00 OFFSET PATIENT TRANSPORT INCOME	B	-3,725	ADMINISTRATIVE & GENERAL		5.06	0	36.00
37.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	37.00
38.00 OFFSET CHILDCARE INCOME	B	-313,748	ADMINISTRATIVE & GENERAL		5.06	0	38.00
39.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	39.00
39.01 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	39.01
39.02 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	39.02
39.03 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	39.03
39.04 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	39.04
39.05 ANESTHESIOLOGY INCOME	B	-8,610	ANESTHESIOLOGY		53.00	0	39.05
39.06 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	39.06
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1,581,523					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: 14-2011
 Period: From 01/01/2018 To 06/30/2018
 Worksheet A-8-1
 Date/Time Prepared: 11/28/2018 1:32 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	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE CAPITAL	-301,549	0
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE CAPITAL	6,024	0
3.00	5.06	ADMINISTRATIVE & GENERAL	ADMIN & GENERAL	5,440,431	4,573,767
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	EH&W	55,981	0
3.02	5.02	DATA PROCESSING	DATA PROCESSING	878,306	0
3.03	5.03	PURCHASING RECEIVING AND STO	PURCHASING	-38,813	0
3.04	5.05	CASHIERING/ACCOUNTS RECEIVAB	PATIENT ACCTS	872,137	0
3.05	31.00	INTENSIVE CARE UNIT	ELECTRONIC ICU	71,720	0
3.06	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	281,859	0
3.07	60.00	LABORATORY	ALVERNO LAB	1,092,965	1,087,082
3.08	0.00			0	0
4.00	0.00			0	0
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			8,359,061	5,660,849

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

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

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

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

6.00	B	RESURRECTION HEALTH CARE	100.00	0.00	6.00
7.00	C	ALVERNO LAB	66.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-2011

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

Worksheet A-8-2

Date/Time Prepared:
11/28/2018 1:32 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	5.06	ADMINISTRATIVE & GENERAL	532,266	177,036	355,230	179,000	2,842	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	170,085	170,085	0	0	0	3.00
4.00	60.00	LABORATORY	37,556	37,556	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	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			739,907	384,677	355,230		2,842	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	5.06	ADMINISTRATIVE & GENERAL	244,576	12,229	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	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			244,576	12,229	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.06	ADMINISTRATIVE & GENERAL	0	244,576	110,654	287,690	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	170,085	3.00
4.00	60.00	LABORATORY	0	0	0	37,556	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	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			0	244,576	110,654	495,331	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-2011

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

Worksheet B
Part I
Date/Time Prepared:
11/28/2018 1:32 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	378,388	378,388			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	2,492,940		2,492,940		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	-192,247	0	0	-192,247	4.00
5.01 00540	NONPATIENT TELEPHONES	97,828	3,392	22,346	0	123,566 5.01
5.02 00550	DATA PROCESSING	878,306	0	0	0	8,402 5.02
5.03 00560	PURCHASING RECEIVING AND STORES	-38,813	9,286	61,180	0	2,801 5.03
5.04 00570	ADMINISTRATIVE	0	0	0	0	0 5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	872,137	0	0	0	6,274 5.05
5.06 00590	ADMINISTRATIVE & GENERAL	10,841,187	58,422	384,903	0	21,845 5.06
6.00 00600	MAINTENANCE & REPAIRS	380,309	16,665	109,793	0	1,680 6.00
7.00 00700	OPERATION OF PLANT	1,274,209	63,333	417,248	0	2,353 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	102,412	7,393	48,710	0	0 8.00
9.00 00900	HOUSEKEEPING	671,326	5,232	34,468	0	896 9.00
10.00 01000	DIETARY	544,409	21,482	141,530	0	784 10.00
11.00 01100	CAFETERIA	177,301	0	0	0	1,120 11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00 01300	NURSING ADMINISTRATION	645,021	0	0	0	224 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	-89,709	10,413	68,606	0	1,120 14.00
15.00 01500	PHARMACY	553,521	6,009	39,589	0	2,465 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	281,859	5,740	37,817	0	8,178 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	193,046	0	0	0	0 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0 22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	6,596,817	50,212	330,811	0	30,808 30.00
31.00 03100	INTENSIVE CARE UNIT	1,088,626	5,725	37,721	0	560 31.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	877,120	41,735	274,966	0	9,858 50.00
53.00 05300	ANESTHESIOLOGY	802	165	1,084	0	784 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	327,322	11,180	73,660	0	9,522 54.00
56.00 05600	RADIOISOTOPE	37,171	1,932	12,732	0	0 56.00
57.00 05700	CT SCAN	53,900	761	5,015	0	0 57.00
57.01 03630	ULTRA SOUND	62,701	1,051	6,923	0	0 57.01
58.00 05800	MRI	0	0	0	0	224 58.00
60.00 06000	LABORATORY	1,174,241	9,590	63,184	0	6,610 60.00
65.00 06500	RESPIRATORY THERAPY	1,760,932	782	5,151	0	2,689 65.00
66.00 06600	PHYSICAL THERAPY	1,278,214	17,571	115,766	0	2,465 66.00
69.00 06900	ELECTROCARDIOLOGY	32,153	2,107	13,884	0	0 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	123,926	4,497	29,627	0	1,344 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,227,506	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	161,615	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,645,413	0	0	0	0 73.00
74.00 07400	RENAL DIALYSIS	306,493	481	3,166	0	112 74.00
76.00 03950	SUBSTANCE ABUSE	449,589	13,180	86,837	0	0 76.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98 07698	HYPERBARI C OXYGEN THERAPY	408,575	701	4,618	0	224 76.98
76.99 07699	LI THOTRI PSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	918	5,163	34,012	0	0 90.00
90.02 09001	WOMENS DIAGNOSTIC CENTER	40,871	4,188	27,593	0	224 90.02
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	37,718,335	378,388	2,492,940	0	123,566 118.00
NONREIMBURSABLE COST CENTERS						
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	-192,247	0 201.00
202.00	TOTAL (sum lines 118 through 201)	37,718,335	378,388	2,492,940	-192,247	123,566 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMINITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	
		5.02	5.03	5.04	5.05	5A.05	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING	886,708				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	18,245	52,699			5.03
5.04	00570	ADMINITTING	0	0	0		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	80,278	0	0	958,689	5.05
5.06	00590	ADMINISTRATIVE & GENERAL	270,027	492	0	0	11,576,876
6.00	00600	MAINTENANCE & REPAIRS	10,947	1,060	0	0	520,454
7.00	00700	OPERATION OF PLANT	3,649	1,119	0	0	1,761,911
8.00	00800	LAUNDRY & LINEN SERVICE	3,649	889	0	0	163,053
9.00	00900	HOUSEKEEPING	3,649	1,123	0	0	716,694
10.00	01000	DIETARY	3,649	5,516	0	0	717,370
11.00	01100	CAFETERIA	3,649	0	0	0	182,070
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	0	91	0	0	645,336
14.00	01400	CENTRAL SERVICES & SUPPLY	3,649	1,824	0	0	-4,097
15.00	01500	PHARMACY	18,245	230	0	0	620,059
16.00	01600	MEDICAL RECORDS & LIBRARY	80,278	0	0	0	413,872
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	193,046
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	51,086	14,122	0	308,819	7,382,675
31.00	03100	INTENSIVE CARE UNIT	0	1,999	0	29,798	1,164,429
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	47,437	11,757	0	51,142	1,314,015
53.00	05300	ANESTHESIOLOGY	0	194	0	9,759	12,788
54.00	05400	RADIOLOGY-DIAGNOSTIC	120,417	1,320	0	12,893	556,314
56.00	05600	RADIOISOTOPE	0	157	0	1,155	53,147
57.00	05700	CT SCAN	0	32	0	11,667	71,375
57.01	03630	ULTRA SOUND	0	13	0	9,122	79,810
58.00	05800	MRI	3,649	0	0	0	3,873
60.00	06000	LABORATORY	94,874	1,678	0	73,268	1,423,445
65.00	06500	RESPIRATORY THERAPY	18,245	3,123	0	165,931	1,956,853
66.00	06600	PHYSICAL THERAPY	36,490	200	0	36,255	1,486,961
69.00	06900	ELECTROCARDIOLOGY	0	5	0	5,920	54,069
70.00	07000	ELECTROENCEPHALOGRAPHY	10,947	45	0	7,216	177,602
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	31,458	1,258,964
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	8,034	169,649
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	143,610	1,789,023
74.00	07400	RENAL DIALYSIS	0	646	0	18,886	329,784
76.00	03950	SUBSTANCE ABUSE	0	46	0	8,383	558,035
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	4,985	0	21,718	440,821
76.99	07699	LITHOTRIpsy	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	5	0	0	40,098
90.02	09001	WOMENS DIAGNOSTIC CENTER	3,649	28	0	3,655	80,208
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	886,708	52,699	0	958,689	37,910,582
NONREIMBURSABLE COST CENTERS							
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers	0	0	0	0	-192,247
202.00		TOTAL (sum lines 118 through 201)	886,708	52,699	0	958,689	37,718,335

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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.06	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
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	ADMINISTRATIVE & GENERAL	11,576,876				5.06
6.00	00600	MAINTENANCE & REPAIRS	228,768	749,222			6.00
7.00	00700	OPERATION OF PLANT	774,455	163,268	2,699,634		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	71,671	19,060	87,814	341,598	8.00
9.00	00900	HOUSEKEEPING	315,026	13,487	62,138	0	1,107,345
10.00	01000	DIETARY	315,323	55,380	255,150	0	110,813
11.00	01100	CAFETERIA	80,030	0	0	0	0
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	283,660	0	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	26,845	123,683	0	53,716
15.00	01500	PHARMACY	272,549	15,491	71,371	0	30,997
16.00	01600	MEDICAL RECORDS & LIBRARY	181,919	14,798	68,177	0	29,610
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	84,854	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,245,071	129,445	596,383	265,811	259,014
31.00	03100	INTENSIVE CARE UNIT	511,829	14,760	68,003	23,960	29,534
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	577,581	107,593	495,708	22,428	215,289
53.00	05300	ANESTHESIOLOGY	5,621	424	1,955	0	849
54.00	05400	RADIOLOGY-DIAGNOSTIC	244,530	28,823	132,794	605	57,673
56.00	05600	RADIOISOTOPE	23,361	4,982	22,953	0	9,969
57.00	05700	CT SCAN	31,373	1,962	9,041	827	3,927
57.01	03630	ULTRA SOUND	35,081	2,709	12,480	1,136	5,420
58.00	05800	MRI	1,702	0	0	0	0
60.00	06000	LABORATORY	625,681	24,724	113,908	0	49,471
65.00	06500	RESPIRATORY THERAPY	860,143	2,015	9,286	48	4,033
66.00	06600	PHYSICAL THERAPY	653,600	45,299	208,703	11,547	90,641
69.00	06900	ELECTROCARDIOLOGY	23,766	5,433	25,030	56	10,871
70.00	07000	ELECTROENCEPHALOGRAPHY	78,066	11,593	53,411	188	23,197
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	553,383	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	74,570	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	786,372	0	0	0	0
74.00	07400	RENAL DIALYSIS	144,958	1,239	5,708	0	2,479
76.00	03950	SUBSTANCE ABUSE	245,287	33,979	156,549	3,661	67,990
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	193,765	1,807	8,326	10,260	3,616
76.99	07699	LI THOTRI PSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	17,625	13,309	61,318	0	26,631
90.02	09001	WOMENS DIAGNOSTIC CENTER	35,256	10,797	49,745	1,071	21,605
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,576,876	749,222	2,699,634	341,598	1,107,345
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)	11,576,876	749,222	2,699,634	341,598	1,107,345

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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMINITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	ADMINISTRATIVE & GENERAL						5.06
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	1,454,036					10.00
11.00	01100	CAFETERIA	0	262,100				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	5,092	0	934,088		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,537	0	153	201,837	14.00
15.00	01500	PHARMACY	0	7,565	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,404,418	137,820	0	649,747	0	30.00
31.00	03100	INTENSIVE CARE UNIT	49,618	14,402	0	120,759	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	10,744	0	65,494	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,787	0	5,343	0	54.00
56.00	05600	RADIOISOTOPE	0	344	0	0	0	56.00
57.00	05700	CT SCAN	0	464	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	889	0	76	0	57.01
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	31,679	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	23,345	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	528	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,634	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	181,809	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	20,028	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	4,731	0	25,343	0	74.00
76.00	03950	SUBSTANCE ABUSE	0	8,622	0	22,213	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	6,108	0	44,731	0	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	24	0	229	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	785	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,454,036	262,100	0	934,088	201,837	118.00
NONREIMBURSABLE COST CENTERS								
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,454,036	262,100	0	934,088	201,837	202.00

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Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		
				SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	
				15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 00540 NONPATIENT TELEPHONES						5.01
5.02 00550 DATA PROCESSING						5.02
5.03 00560 PURCHASING RECEIVING AND STORES						5.03
5.04 00570 ADMITTING						5.04
5.05 00580 CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06 00590 ADMINISTRATIVE & GENERAL						5.06
6.00 00600 MAINTENANCE & REPAIRS						6.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPING						9.00
10.00 01000 DIETARY						10.00
11.00 01100 CAFETERIA						11.00
12.00 01200 MAINTENANCE OF PERSONNEL						12.00
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 01500 PHARMACY	1,018,032					15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	708,376				16.00
17.00 01700 SOCIAL SERVICE	0	0	0			17.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	277,900		21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0		0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	0	228,233	0	277,900	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	22,016	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	37,785	0	0	0	50.00
53.00 05300 ANESTHESIOLOGY	0	7,210	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	9,526	0	0	0	54.00
56.00 05600 RADIOISOTOPE	0	853	0	0	0	56.00
57.00 05700 CT SCAN	0	8,620	0	0	0	57.00
57.01 03630 ULTRA SOUND	0	6,740	0	0	0	57.01
58.00 05800 MRI	0	0	0	0	0	58.00
60.00 06000 LABORATORY	0	54,132	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	122,594	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	26,786	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	4,374	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	5,332	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	23,242	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	5,936	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1,018,032	106,103	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	13,954	0	0	0	74.00
76.00 03950 SUBSTANCE ABUSE	0	6,194	0	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	16,046	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.02 09001 WOMENS DIAGNOSTIC CENTER	0	2,700	0	0	0	90.02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,018,032	708,376	0	277,900	0
NONREIMBURSABLE COST CENTERS						
200.00	Cross Foot Adjustments				0	0
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	1,018,032	708,376	0	277,900	0

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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.01	00540				5.01
5.02	00550				5.02
5.03	00560				5.03
5.04	00570				5.04
5.05	00580				5.05
5.06	00590				5.06
6.00	00600				6.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
12.00	01200				12.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
21.00	02100				21.00
22.00	02200				22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	14,576,517	-277,900	14,298,617	30.00
31.00	03100	2,019,310	0	2,019,310	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	2,846,637	0	2,846,637	50.00
53.00	05300	28,847	0	28,847	53.00
54.00	05400	1,040,395	0	1,040,395	54.00
56.00	05600	115,609	0	115,609	56.00
57.00	05700	127,589	0	127,589	57.00
57.01	03630	144,341	0	144,341	57.01
58.00	05800	5,575	0	5,575	58.00
60.00	06000	2,291,361	0	2,291,361	60.00
65.00	06500	2,986,651	0	2,986,651	65.00
66.00	06600	2,546,882	0	2,546,882	66.00
69.00	06900	124,127	0	124,127	69.00
70.00	07000	352,023	0	352,023	70.00
71.00	07100	2,017,398	0	2,017,398	71.00
72.00	07200	270,183	0	270,183	72.00
73.00	07300	3,699,530	0	3,699,530	73.00
74.00	07400	528,196	0	528,196	74.00
76.00	03950	1,102,530	0	1,102,530	76.00
76.97	07697	0	0	0	76.97
76.98	07698	725,480	0	725,480	76.98
76.99	07699	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	159,234	0	159,234	90.00
90.02	09001	202,167	0	202,167	90.02
92.00	09200		0		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
118.00		37,910,582	-277,900	37,632,682	118.00
NONREIMBURSABLE COST CENTERS					
200.00		0	0	0	200.00
201.00		-192,247	0	-192,247	201.00
202.00		37,718,335	-277,900	37,440,435	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-2011

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

Worksheet B
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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	0	0	0	4.00
5.01 00540	NONPATIENT TELEPHONES	0	3,392	22,346	25,738	5.01
5.02 00550	DATA PROCESSING	0	0	0	0	5.02
5.03 00560	PURCHASING RECEIVING AND STORES	0	9,286	61,180	70,466	5.03
5.04 00570	ADMITTING	0	0	0	0	5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	5.05
5.06 00590	ADMINISTRATIVE & GENERAL	0	58,422	384,903	443,325	5.06
6.00 00600	MAINTENANCE & REPAIRS	0	16,665	109,793	126,458	6.00
7.00 00700	OPERATION OF PLANT	0	63,333	417,248	480,581	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	7,393	48,710	56,103	8.00
9.00 00900	HOUSEKEEPING	0	5,232	34,468	39,700	9.00
10.00 01000	DIETARY	0	21,482	141,530	163,012	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	10,413	68,606	79,019	14.00
15.00 01500	PHARMACY	0	6,009	39,589	45,598	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	5,740	37,817	43,557	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	50,212	330,811	381,023	30.00
31.00 03100	INTENSIVE CARE UNIT	0	5,725	37,721	43,446	31.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	41,735	274,966	316,701	50.00
53.00 05300	ANESTHESIOLOGY	0	165	1,084	1,249	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	11,180	73,660	84,840	54.00
56.00 05600	RADIOISOTOPE	0	1,932	12,732	14,664	56.00
57.00 05700	CT SCAN	0	761	5,015	5,776	57.00
57.01 03630	ULTRA SOUND	0	1,051	6,923	7,974	57.01
58.00 05800	MRI	0	0	0	0	58.00
60.00 06000	LABORATORY	0	9,590	63,184	72,774	60.00
65.00 06500	RESPIRATORY THERAPY	0	782	5,151	5,933	65.00
66.00 06600	PHYSICAL THERAPY	0	17,571	115,766	133,337	66.00
69.00 06900	ELECTROCARDIOLOGY	0	2,107	13,884	15,991	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	4,497	29,627	34,124	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	481	3,166	3,647	74.00
76.00 03950	SUBSTANCE ABUSE	0	13,180	86,837	100,017	76.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	701	4,618	5,319	76.98
76.99 07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	5,163	34,012	39,175	90.00
90.02 09001	WOMENS DIAGNOSTIC CENTER	0	4,188	27,593	31,781	90.02
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	378,388	2,492,940	2,871,328	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)	0	378,388	2,492,940	2,871,328	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-2011

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

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Part II
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Cost Center Description			NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMINING	CASHIERING/ACCOUNTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	25,738					5.01
5.02	00550	DATA PROCESSING	1,750	1,750				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	583	36	40,936			5.03
5.04	00570	ADMINING	0	0	0	0		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,307	158	0	0	1,465	5.05
5.06	00590	ADMINISTRATIVE & GENERAL	4,550	534	382	0	0	5.06
6.00	00600	MAINTENANCE & REPAIRS	350	22	824	0	0	6.00
7.00	00700	OPERATION OF PLANT	490	7	869	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	7	691	0	0	8.00
9.00	00900	HOUSEKEEPING	187	7	872	0	0	9.00
10.00	01000	DIETARY	163	7	4,285	0	0	10.00
11.00	01100	CAFETERIA	233	7	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	47	0	71	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	233	7	1,417	0	0	14.00
15.00	01500	PHARMACY	513	36	178	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,703	158	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,419	101	10,968	0	440	30.00
31.00	03100	INTENSIVE CARE UNIT	117	0	1,553	0	47	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,053	94	9,133	0	81	50.00
53.00	05300	ANESTHESIOLOGY	163	0	151	0	15	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,983	238	1,026	0	20	54.00
56.00	05600	RADIOISOTOPE	0	0	122	0	2	56.00
57.00	05700	CT SCAN	0	0	25	0	18	57.00
57.01	03630	ULTRA SOUND	0	0	10	0	14	57.01
58.00	05800	MRI	47	7	0	0	0	58.00
60.00	06000	LABORATORY	1,377	187	1,303	0	116	60.00
65.00	06500	RESPIRATORY THERAPY	560	36	2,426	0	262	65.00
66.00	06600	PHYSICAL THERAPY	513	72	155	0	57	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	4	0	9	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	280	22	35	0	11	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	50	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	13	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	227	73.00
74.00	07400	RENAL DIALYSIS	23	0	502	0	30	74.00
76.00	03950	SUBSTANCE ABUSE	0	0	36	0	13	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	47	0	3,872	0	34	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	4	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	47	7	22	0	6	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,738	1,750	40,936	0	1,465	118.00
NONREIMBURSABLE COST CENTERS								
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	30,149	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	25,738	1,750	71,085	0	1,465	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-2011		Period: From 01/01/2018 To 06/30/2018		Worksheet B Part II Date/Time Prepared: 11/28/2018 1:32 pm	
Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.06	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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	ADMINISTRATIVE & GENERAL	448,791					5.06
6.00	00600	MAINTENANCE & REPAIRS	8,869	136,523				6.00
7.00	00700	OPERATION OF PLANT	30,023	29,751	541,721			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,778	3,473	17,621	80,673		8.00
9.00	00900	HOUSEKEEPING	12,212	2,458	12,469	0	67,905	9.00
10.00	01000	DIETARY	12,224	10,091	51,200	0	6,795	10.00
11.00	01100	CAFETERIA	3,102	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	10,997	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,892	24,819	0	3,294	14.00
15.00	01500	PHARMACY	10,566	2,823	14,322	0	1,901	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,052	2,696	13,681	0	1,816	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	3,290	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	125,793	23,587	119,673	62,775	15,884	30.00
31.00	03100	INTENSIVE CARE UNIT	19,842	2,690	13,646	5,659	1,811	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	22,391	19,606	99,471	5,297	13,202	50.00
53.00	05300	ANESTHESIOLOGY	218	77	392	0	52	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,480	5,252	26,647	143	3,537	54.00
56.00	05600	RADIOISOTOPE	906	908	4,606	0	611	56.00
57.00	05700	CT SCAN	1,216	358	1,814	195	241	57.00
57.01	03630	ULTRASOUND	1,360	494	2,504	268	332	57.01
58.00	05800	MRI	66	0	0	0	0	58.00
60.00	06000	LABORATORY	24,256	4,505	22,857	0	3,034	60.00
65.00	06500	RESPIRATORY THERAPY	33,345	367	1,863	11	247	65.00
66.00	06600	PHYSICAL THERAPY	25,338	8,254	41,879	2,727	5,558	66.00
69.00	06900	ELECTROCARDIOLOGY	921	990	5,023	13	667	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,026	2,112	10,718	44	1,422	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	21,453	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,891	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	30,485	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	5,620	226	1,145	0	152	74.00
76.00	03950	SUBSTANCE ABUSE	9,509	6,192	31,414	865	4,169	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	7,512	329	1,671	2,423	222	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	683	2,425	12,304	0	1,633	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	1,367	1,967	9,982	253	1,325	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	448,791	136,523	541,721	80,673	67,905	118.00
NONREIMBURSABLE COST CENTERS								
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	448,791	136,523	541,721	80,673	67,905	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-2011		Period: From 01/01/2018 To 06/30/2018		Worksheet B Part II Date/Time Prepared: 11/28/2018 1:32 pm	
Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMINITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	ADMINISTRATIVE & GENERAL						5.06
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	247,777					10.00
11.00	01100	CAFETERIA	0	3,342				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	65	0	11,180		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	20	0	2	78,716	14.00
15.00	01500	PHARMACY	0	96	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	239,322	1,757	0	7,777	0	30.00
31.00	03100	INTENSIVE CARE UNIT	8,455	184	0	1,445	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	137	0	784	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	61	0	64	0	54.00
56.00	05600	RADIOISOTOPE	0	4	0	0	0	56.00
57.00	05700	CT SCAN	0	6	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	11	0	1	0	57.01
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	404	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	298	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	7	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	34	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	70,905	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	7,811	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	60	0	303	0	74.00
76.00	03950	SUBSTANCE ABUSE	0	110	0	266	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	78	0	535	0	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	3	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	10	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	247,777	3,342	0	11,180	78,716	118.00
NONREIMBURSABLE COST CENTERS								
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	34,987	201.00
202.00		TOTAL (sum lines 118 through 201)	247,777	3,342	0	11,180	113,703	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-2011

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		
				SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	
				15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 00540 NONPATIENT TELEPHONES						5.01
5.02 00550 DATA PROCESSING						5.02
5.03 00560 PURCHASING RECEIVING AND STORES						5.03
5.04 00570 ADMITTING						5.04
5.05 00580 CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06 00590 ADMINISTRATIVE & GENERAL						5.06
6.00 00600 MAINTENANCE & REPAIRS						6.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPING						9.00
10.00 01000 DIETARY						10.00
11.00 01100 CAFETERIA						11.00
12.00 01200 MAINTENANCE OF PERSONNEL						12.00
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 01500 PHARMACY	76,033					15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	70,663				16.00
17.00 01700 SOCIAL SERVICE	0	0	0			17.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	3,290		21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0		0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	0	22,739	0			30.00
31.00 03100 INTENSIVE CARE UNIT	0	2,197	0			31.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	3,771	0			50.00
53.00 05300 ANESTHESIOLOGY	0	720	0			53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	951	0			54.00
56.00 05600 RADIOISOTOPE	0	85	0			56.00
57.00 05700 CT SCAN	0	860	0			57.00
57.01 03630 ULTRA SOUND	0	673	0			57.01
58.00 05800 MRI	0	0	0			58.00
60.00 06000 LABORATORY	0	5,403	0			60.00
65.00 06500 RESPIRATORY THERAPY	0	12,236	0			65.00
66.00 06600 PHYSICAL THERAPY	0	2,674	0			66.00
69.00 06900 ELECTROCARDIOLOGY	0	437	0			69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	532	0			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,320	0			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	592	0			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	76,033	10,590	0			73.00
74.00 07400 RENAL DIALYSIS	0	1,393	0			74.00
76.00 03950 SUBSTANCE ABUSE	0	618	0			76.00
76.97 07697 CARDIAC REHABILITATION	0	0	0			76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	1,602	0			76.98
76.99 07699 LI THOTRI PSY	0	0	0			76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0			90.00
90.02 09001 WOMENS DIAGNOSTIC CENTER	0	270	0			90.02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	76,033	70,663	0	0	118.00
NONREIMBURSABLE COST CENTERS						
200.00	Cross Foot Adjustments				3,290	0 200.00
201.00	Negative Cost Centers	0	0	0	0	0 201.00
202.00	TOTAL (sum lines 118 through 201)	76,033	70,663	0	3,290	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-2011	Period: From 01/01/2018 To 06/30/2018	Worksheet B Part II Date/Time Prepared: 11/28/2018 1:32 pm
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.01	00540				5.01
5.02	00550				5.02
5.03	00560				5.03
5.04	00570				5.04
5.05	00580				5.05
5.06	00590				5.06
6.00	00600				6.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
12.00	01200				12.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
21.00	02100				21.00
22.00	02200				22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	1,018,258	0	1,018,258	30.00
31.00	03100	101,092	0	101,092	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	492,721	0	492,721	50.00
53.00	05300	3,037	0	3,037	53.00
54.00	05400	134,242	0	134,242	54.00
56.00	05600	21,908	0	21,908	56.00
57.00	05700	10,509	0	10,509	57.00
57.01	03630	13,641	0	13,641	57.01
58.00	05800	120	0	120	58.00
60.00	06000	135,812	0	135,812	60.00
65.00	06500	57,690	0	57,690	65.00
66.00	06600	220,862	0	220,862	66.00
69.00	06900	24,062	0	24,062	69.00
70.00	07000	52,360	0	52,360	70.00
71.00	07100	94,728	0	94,728	71.00
72.00	07200	11,307	0	11,307	72.00
73.00	07300	117,335	0	117,335	73.00
74.00	07400	13,101	0	13,101	74.00
76.00	03950	153,209	0	153,209	76.00
76.97	07697	0	0	0	76.97
76.98	07698	23,644	0	23,644	76.98
76.99	07699	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	56,227	0	56,227	90.00
90.02	09001	47,037	0	47,037	90.02
92.00	09200		0		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
118.00		2,802,902	0	2,802,902	118.00
NONREIMBURSABLE COST CENTERS					
200.00		3,290	0	3,290	200.00
201.00		65,136	0	65,136	201.00
202.00		2,871,328	0	2,871,328	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-2011

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF LINES)	DATA PROCESSING (NUMBER OF INSTRUMENT)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	257,485				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		257,485			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	14,288,184		4.00
5.01 00540	NONPATIENT TELEPHONES	2,308	2,308	0	1,103	5.01
5.02 00550	DATA PROCESSING	0	0	0	75	243 5.02
5.03 00560	PURCHASING RECEIVING AND STORES	6,319	6,319	0	25	5 5.03
5.04 00570	ADMINISTRATIVE	0	0	0	0	0 5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	56	22 5.05
5.06 00590	ADMINISTRATIVE & GENERAL	39,755	39,755	2,080,970	195	74 5.06
6.00 00600	MAINTENANCE & REPAIRS	11,340	11,340	184,308	15	3 6.00
7.00 00700	OPERATION OF PLANT	43,096	43,096	197,408	21	1 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	5,031	5,031	37,634	0	1 8.00
9.00 00900	HOUSEKEEPING	3,560	3,560	399,936	8	1 9.00
10.00 01000	DIETARY	14,618	14,618	156,121	7	1 10.00
11.00 01100	CAFETERIA	0	0	83,476	10	1 11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00 01300	NURSING ADMINISTRATION	0	0	329,058	2	0 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	7,086	7,086	50,284	10	1 14.00
15.00 01500	PHARMACY	4,089	4,089	436,172	22	5 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	3,906	3,906	0	73	22 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	176,677	0	0 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0 22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	34,168	34,168	5,111,937	275	14 30.00
31.00 03100	INTENSIVE CARE UNIT	3,896	3,896	798,917	5	0 31.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	28,400	28,400	532,903	88	13 50.00
53.00 05300	ANESTHESIOLOGY	112	112	0	7	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	7,608	7,608	257,110	85	33 54.00
56.00 05600	RADIOISOTOPE	1,315	1,315	20,237	0	0 56.00
57.00 05700	CT SCAN	518	518	41,032	0	0 57.00
57.01 03630	ULTRA SOUND	715	715	51,886	0	0 57.01
58.00 05800	MRI	0	0	0	2	1 58.00
60.00 06000	LABORATORY	6,526	6,526	0	59	26 60.00
65.00 06500	RESPIRATORY THERAPY	532	532	1,288,040	24	5 65.00
66.00 06600	PHYSICAL THERAPY	11,957	11,957	1,024,143	22	10 66.00
69.00 06900	ELECTROCARDIOLOGY	1,434	1,434	26,404	0	0 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	3,060	3,060	94,115	12	3 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00 07400	RENAL DIALYSIS	327	327	223,707	1	0 74.00
76.00 03950	SUBSTANCE ABUSE	8,969	8,969	355,176	0	0 76.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98 07698	HYPERBARI C OXYGEN THERAPY	477	477	302,185	2	0 76.98
76.99 07699	LI THOTRI PSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	3,513	3,513	43	0	0 90.00
90.02 09001	WOMENS DIAGNOSTIC CENTER	2,850	2,850	28,305	2	1 90.02
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	257,485	257,485	14,288,184	1,103	243 118.00
NONREIMBURSABLE COST CENTERS						
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	378,388	2,492,940	-192,247	123,566	886,708 202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1.469554	9.681884	0.000000	112.027199	3,649.004115 203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0	25,738	1,750 204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000	23.334542	7.201646 205.00
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: 14-2011

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

Worksheet B-1

Date/Time Prepared:
11/28/2018 1:32 pm

Cost Center Description			PURCHASING RECEIVING AND STORES (COST OF REQUISITIONS)	ADMITTING (INPATIENT REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES	2,556,123					5.03
5.04	00570	ADMITTING	0	0				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	189,549,013			5.05
5.06	00590	ADMINISTRATIVE & GENERAL	23,853	0	0	-11,576,876	26,337,803	5.06
6.00	00600	MAINTENANCE & REPAIRS	51,427	0	0	0	520,454	6.00
7.00	00700	OPERATION OF PLANT	54,252	0	0	0	1,761,911	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	43,142	0	0	0	163,053	8.00
9.00	00900	HOUSEKEEPING	54,477	0	0	0	716,694	9.00
10.00	01000	DIETARY	267,534	0	0	0	717,370	10.00
11.00	01100	CAFETERIA	0	0	0	0	182,070	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	4,419	0	0	0	645,336	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	88,491	0	0	4,097	0	14.00
15.00	01500	PHARMACY	11,138	0	0	0	620,059	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	413,872	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	193,046	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	684,947	0	61,065,292	0	7,382,675	30.00
31.00	03100	INTENSIVE CARE UNIT	96,966	0	5,891,350	0	1,164,429	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	570,258	0	10,111,157	0	1,314,015	50.00
53.00	05300	ANESTHESIOLOGY	9,411	0	1,929,375	0	12,788	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	64,045	0	2,549,052	0	556,314	54.00
56.00	05600	RADIOISOTOPE	7,628	0	228,342	0	53,147	56.00
57.00	05700	CT SCAN	1,556	0	2,306,645	0	71,375	57.00
57.01	03630	ULTRA SOUND	625	0	1,803,493	0	79,810	57.01
58.00	05800	MRI	0	0	0	0	3,873	58.00
60.00	06000	LABORATORY	81,392	0	14,485,503	0	1,423,445	60.00
65.00	06500	RESPIRATORY THERAPY	151,461	0	32,805,580	0	1,956,853	65.00
66.00	06600	PHYSICAL THERAPY	9,709	0	7,167,884	0	1,486,961	66.00
69.00	06900	ELECTROCARDIOLOGY	261	0	1,170,348	0	54,069	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,161	0	1,426,722	0	177,602	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	6,219,479	0	1,258,964	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,588,379	0	169,649	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	28,392,680	0	1,789,023	73.00
74.00	07400	RENAL DIALYSIS	31,316	0	3,733,956	0	329,784	74.00
76.00	03950	SUBSTANCE ABUSE	2,254	0	1,657,361	0	558,035	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	241,775	0	4,293,870	0	440,821	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	246	0	0	0	40,098	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	1,379	0	722,545	0	80,208	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,556,123	0	189,549,013	-11,572,779	26,337,803	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)	52,699	0	958,689		11,576,876	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.020617	0.000000	0.005058		0.439554	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	71,085	0	1,465		448,791	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.016015	0.000000	0.000008		0.017040	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: 14-2011

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

Worksheet B-1

Date/Time Prepared:
11/28/2018 1:32 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00590						5.06
6.00	00600	197,763					6.00
7.00	00700	43,096	154,667				7.00
8.00	00800	5,031	5,031	183,444			8.00
9.00	00900	3,560	3,560	0	146,076		9.00
10.00	01000	14,618	14,618	0	14,618	44,133	10.00
11.00	01100	0	0	0	0	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	0	0	0	0	0	13.00
14.00	01400	7,086	7,086	0	7,086	0	14.00
15.00	01500	4,089	4,089	0	4,089	0	15.00
16.00	01600	3,906	3,906	0	3,906	0	16.00
17.00	01700	0	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	34,168	34,168	142,745	34,168	42,627	30.00
31.00	03100	3,896	3,896	12,867	3,896	1,506	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	28,400	28,400	12,044	28,400	0	50.00
53.00	05300	112	112	0	112	0	53.00
54.00	05400	7,608	7,608	325	7,608	0	54.00
56.00	05600	1,315	1,315	0	1,315	0	56.00
57.00	05700	518	518	444	518	0	57.00
57.01	03630	715	715	610	715	0	57.01
58.00	05800	0	0	0	0	0	58.00
60.00	06000	6,526	6,526	0	6,526	0	60.00
65.00	06500	532	532	26	532	0	65.00
66.00	06600	11,957	11,957	6,201	11,957	0	66.00
69.00	06900	1,434	1,434	30	1,434	0	69.00
70.00	07000	3,060	3,060	101	3,060	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	327	327	0	327	0	74.00
76.00	03950	8,969	8,969	1,966	8,969	0	76.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	477	477	5,510	477	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	3,513	3,513	0	3,513	0	90.00
90.02	09001	2,850	2,850	575	2,850	0	90.02
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		197,763	154,667	183,444	146,076	44,133	118.00
NONREIMBURSABLE COST CENTERS							
200.00							200.00
201.00							201.00
202.00		749,222	2,699,634	341,598	1,107,345	1,454,036	202.00
203.00		3.788484	17.454493	1.862138	7.580609	32.946684	203.00
204.00		136,523	541,721	80,673	67,905	247,777	204.00
205.00		0.690336	3.502499	0.439769	0.464861	5.614325	205.00
206.00							206.00
207.00							207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-2011

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

Worksheet B-1

Date/Time Prepared:
11/28/2018 1:32 pm

Cost Center Description		CAFETERIA (FTES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	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
5.01	00540						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00590						5.06
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	32,739					11.00
12.00	01200	0	0				12.00
13.00	01300	636	0	12,237			13.00
14.00	01400	192	0	2	1,630,416		14.00
15.00	01500	945	0	0	0	1,645,413	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	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	17,215	0	8,512	0	0	30.00
31.00	03100	1,799	0	1,582	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,342	0	858	0	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	598	0	70	0	0	54.00
56.00	05600	43	0	0	0	0	56.00
57.00	05700	58	0	0	0	0	57.00
57.01	03630	111	0	1	0	0	57.01
58.00	05800	0	0	0	0	0	58.00
60.00	06000	0	0	0	0	0	60.00
65.00	06500	3,957	0	0	0	0	65.00
66.00	06600	2,916	0	0	0	0	66.00
69.00	06900	66	0	0	0	0	69.00
70.00	07000	329	0	0	0	0	70.00
71.00	07100	0	0	0	1,468,629	0	71.00
72.00	07200	0	0	0	161,787	0	72.00
73.00	07300	0	0	0	0	1,645,413	73.00
74.00	07400	591	0	332	0	0	74.00
76.00	03950	1,077	0	291	0	0	76.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	763	0	586	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	3	0	3	0	0	90.00
90.02	09001	98	0	0	0	0	90.02
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		32,739	0	12,237	1,630,416	1,645,413	118.00
NONREIMBURSABLE COST CENTERS							
200.00							200.00
201.00							201.00
202.00		262,100	0	934,088	201,837	1,018,032	202.00
203.00		8.005742	0.000000	76.333088	0.123795	0.618709	203.00
204.00		3,342	0	11,180	113,703	76,033	204.00
205.00		0.102080	0.000000	0.913623	0.048280	0.046209	205.00
206.00							206.00
207.00							207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-2011

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

Worksheet B-1

Date/Time Prepared:
11/28/2018 1:32 pm

Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	INTERNS & RESIDENTS			
			SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
			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
5.01 00540 NONPATIENT TELEPHONES						5.01
5.02 00550 DATA PROCESSING						5.02
5.03 00560 PURCHASING RECEIVING AND STORES						5.03
5.04 00570 ADMINITTING						5.04
5.05 00580 CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06 00590 ADMINISTRATIVE & GENERAL						5.06
6.00 00600 MAINTENANCE & REPAIRS						6.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPING						9.00
10.00 01000 DIETARY						10.00
11.00 01100 CAFETERIA						11.00
12.00 01200 MAINTENANCE OF PERSONNEL						12.00
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 01500 PHARMACY						15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	189,549,013					16.00
17.00 01700 SOCIAL SERVICE	0	0				17.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0		100			21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		0		22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	61,065,292	0	100	0		30.00
31.00 03100 INTENSIVE CARE UNIT	5,891,350	0	0	0		31.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	10,111,157	0	0	0		50.00
53.00 05300 ANESTHESIOLOGY	1,929,375	0	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	2,549,052	0	0	0		54.00
56.00 05600 RADIOISOTOPE	228,342	0	0	0		56.00
57.00 05700 CT SCAN	2,306,645	0	0	0		57.00
57.01 03630 ULTRA SOUND	1,803,493	0	0	0		57.01
58.00 05800 MRI	0	0	0	0		58.00
60.00 06000 LABORATORY	14,485,503	0	0	0		60.00
65.00 06500 RESPIRATORY THERAPY	32,805,580	0	0	0		65.00
66.00 06600 PHYSICAL THERAPY	7,167,884	0	0	0		66.00
69.00 06900 ELECTROCARDIOLOGY	1,170,348	0	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	1,426,722	0	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	6,219,479	0	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1,588,379	0	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	28,392,680	0	0	0		73.00
74.00 07400 RENAL DIALYSIS	3,733,956	0	0	0		74.00
76.00 03950 SUBSTANCE ABUSE	1,657,361	0	0	0		76.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	0		76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	4,293,870	0	0	0		76.98
76.99 07699 LI THOTRI PSY	0	0	0	0		76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0		90.00
90.02 09001 WOMENS DIAGNOSTIC CENTER	722,545	0	0	0		90.02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	189,549,013	0	100	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)	708,376	0	277,900	0		202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.003737	0.000000	2,779.000000	0.000000		203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	70,663	0	3,290	0		204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.000373	0.000000	32.900000	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: 14-2011

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

Worksheet C
Part I
Date/Time Prepared:
11/28/2018 1:32 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	14,298,617		14,298,617	0	14,298,617	30.00
31.00	03100 INTENSIVE CARE UNIT	2,019,310		2,019,310	0	2,019,310	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	2,846,637		2,846,637	0	2,846,637	50.00
53.00	05300 ANESTHESIOLOGY	28,847		28,847	0	28,847	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,040,395		1,040,395	0	1,040,395	54.00
56.00	05600 RADIOISOTOPE	115,609		115,609	0	115,609	56.00
57.00	05700 CT SCAN	127,589		127,589	0	127,589	57.00
57.01	03630 ULTRA SOUND	144,341		144,341	0	144,341	57.01
58.00	05800 MRI	5,575		5,575	0	5,575	58.00
60.00	06000 LABORATORY	2,291,361		2,291,361	0	2,291,361	60.00
65.00	06500 RESPIRATORY THERAPY	2,986,651	0	2,986,651	0	2,986,651	65.00
66.00	06600 PHYSICAL THERAPY	2,546,882	0	2,546,882	0	2,546,882	66.00
69.00	06900 ELECTROCARDIOLOGY	124,127		124,127	0	124,127	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	352,023		352,023	0	352,023	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2,017,398		2,017,398	0	2,017,398	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	270,183		270,183	0	270,183	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,699,530		3,699,530	0	3,699,530	73.00
74.00	07400 RENAL DIALYSIS	528,196		528,196	0	528,196	74.00
76.00	03950 SUBSTANCE ABUSE	1,102,530		1,102,530	0	1,102,530	76.00
76.97	07697 CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	725,480		725,480	0	725,480	76.98
76.99	07699 LI THOTRI PSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	159,234		159,234	0	159,234	90.00
90.02	09001 WOMENS DIAGNOSTIC CENTER	202,167		202,167	0	202,167	90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	37,632,682	0	37,632,682	0	37,632,682	200.00
201.00	Less Observation Beds	0		0		0	201.00
202.00	Total (see instructions)	37,632,682	0	37,632,682	0	37,632,682	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-2011

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

Worksheet C
Part I
Date/Time Prepared:
11/28/2018 1:32 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	61,065,292		61,065,292			30.00
31.00	03100 INTENSIVE CARE UNIT	5,891,350		5,891,350			31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,449,743	8,661,414	10,111,157	0.281534	0.000000	50.00
53.00	05300 ANESTHESIOLOGY	261,973	1,667,402	1,929,375	0.014951	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,847,712	701,340	2,549,052	0.408150	0.000000	54.00
56.00	05600 RADIOISOTOPE	46,092	182,250	228,342	0.506298	0.000000	56.00
57.00	05700 CT SCAN	1,580,491	726,154	2,306,645	0.055314	0.000000	57.00
57.01	03630 ULTRASOUND	373,935	1,429,558	1,803,493	0.080034	0.000000	57.01
58.00	05800 MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000 LABORATORY	11,018,553	3,466,950	14,485,503	0.158183	0.000000	60.00
65.00	06500 RESPIRATORY THERAPY	32,795,383	10,197	32,805,580	0.091041	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	5,560,054	1,607,830	7,167,884	0.355319	0.000000	66.00
69.00	06900 ELECTROCARDIOLOGY	721,689	448,659	1,170,348	0.106060	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	51,243	1,375,479	1,426,722	0.246736	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5,512,280	707,199	6,219,479	0.324368	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	345,955	1,242,424	1,588,379	0.170100	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	26,139,027	2,253,653	28,392,680	0.130299	0.000000	73.00
74.00	07400 RENAL DIALYSIS	3,288,996	444,960	3,733,956	0.141457	0.000000	74.00
76.00	03950 SUBSTANCE ABUSE	0	1,657,361	1,657,361	0.665232	0.000000	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	1,026	4,292,844	4,293,870	0.168957	0.000000	76.98
76.99	07699 LI THOTRI PSY	0	0	0	0.000000	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0.000000	0.000000	90.00
90.02	09001 WOMENS DIAGNOSTIC CENTER	0	722,545	722,545	0.279798	0.000000	90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	157,950,794	31,598,219	189,549,013			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	157,950,794	31,598,219	189,549,013			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-2011	Period: From 01/01/2018 To 06/30/2018	Worksheet C Part I Date/Time Prepared: 11/28/2018 1:32 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
31.00	03100 INTENSIVE CARE UNIT			31.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.281534		50.00
53.00	05300 ANESTHESIOLOGY	0.014951		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.408150		54.00
56.00	05600 RADIOISOTOPE	0.506298		56.00
57.00	05700 CT SCAN	0.055314		57.00
57.01	03630 ULTRA SOUND	0.080034		57.01
58.00	05800 MRI	0.000000		58.00
60.00	06000 LABORATORY	0.158183		60.00
65.00	06500 RESPIRATORY THERAPY	0.091041		65.00
66.00	06600 PHYSICAL THERAPY	0.355319		66.00
69.00	06900 ELECTROCARDIOLOGY	0.106060		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.246736		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.324368		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.170100		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.130299		73.00
74.00	07400 RENAL DIALYSIS	0.141457		74.00
76.00	03950 SUBSTANCE ABUSE	0.665232		76.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.168957		76.98
76.99	07699 LI THOTRI PSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
90.02	09001 WOMENS DIAGNOSTIC CENTER	0.279798		90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-2011

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

Worksheet C
Part I
Date/Time Prepared:
11/28/2018 1:32 pm

		Title XIX		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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	14,298,617		14,298,617	0	14,298,617	30.00
31.00	03100 INTENSIVE CARE UNIT	2,019,310		2,019,310	0	2,019,310	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	2,846,637		2,846,637	0	2,846,637	50.00
53.00	05300 ANESTHESIOLOGY	28,847		28,847	0	28,847	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,040,395		1,040,395	0	1,040,395	54.00
56.00	05600 RADIOISOTOPE	115,609		115,609	0	115,609	56.00
57.00	05700 CT SCAN	127,589		127,589	0	127,589	57.00
57.01	03630 ULTRA SOUND	144,341		144,341	0	144,341	57.01
58.00	05800 MRI	5,575		5,575	0	5,575	58.00
60.00	06000 LABORATORY	2,291,361		2,291,361	0	2,291,361	60.00
65.00	06500 RESPIRATORY THERAPY	2,986,651	0	2,986,651	0	2,986,651	65.00
66.00	06600 PHYSICAL THERAPY	2,546,882	0	2,546,882	0	2,546,882	66.00
69.00	06900 ELECTROCARDIOLOGY	124,127		124,127	0	124,127	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	352,023		352,023	0	352,023	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2,017,398		2,017,398	0	2,017,398	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	270,183		270,183	0	270,183	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,699,530		3,699,530	0	3,699,530	73.00
74.00	07400 RENAL DIALYSIS	528,196		528,196	0	528,196	74.00
76.00	03950 SUBSTANCE ABUSE	1,102,530		1,102,530	0	1,102,530	76.00
76.97	07697 CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	725,480		725,480	0	725,480	76.98
76.99	07699 LI THOTRI PSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	159,234		159,234	0	159,234	90.00
90.02	09001 WOMENS DIAGNOSTIC CENTER	202,167		202,167	0	202,167	90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	37,632,682	0	37,632,682	0	37,632,682	200.00
201.00	Less Observation Beds	0		0		0	201.00
202.00	Total (see instructions)	37,632,682	0	37,632,682	0	37,632,682	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-2011

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

Worksheet C
Part I
Date/Time Prepared:
11/28/2018 1:32 pm

		Title XIX			Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	61,065,292		61,065,292		30.00
31.00	03100	INTENSIVE CARE UNIT	5,891,350		5,891,350		31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,449,743	8,661,414	10,111,157	0.281534	50.00
53.00	05300	ANESTHESIOLOGY	261,973	1,667,402	1,929,375	0.014951	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,847,712	701,340	2,549,052	0.408150	54.00
56.00	05600	RADIOISOTOPE	46,092	182,250	228,342	0.506298	56.00
57.00	05700	CT SCAN	1,580,491	726,154	2,306,645	0.055314	57.00
57.01	03630	ULTRA SOUND	373,935	1,429,558	1,803,493	0.080034	57.01
58.00	05800	MRI	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	11,018,553	3,466,950	14,485,503	0.158183	60.00
65.00	06500	RESPIRATORY THERAPY	32,795,383	10,197	32,805,580	0.091041	65.00
66.00	06600	PHYSICAL THERAPY	5,560,054	1,607,830	7,167,884	0.355319	66.00
69.00	06900	ELECTROCARDIOLOGY	721,689	448,659	1,170,348	0.106060	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	51,243	1,375,479	1,426,722	0.246736	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,512,280	707,199	6,219,479	0.324368	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	345,955	1,242,424	1,588,379	0.170100	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,139,027	2,253,653	28,392,680	0.130299	73.00
74.00	07400	RENAL DIALYSIS	3,288,996	444,960	3,733,956	0.141457	74.00
76.00	03950	SUBSTANCE ABUSE	0	1,657,361	1,657,361	0.665232	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,026	4,292,844	4,293,870	0.168957	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	722,545	722,545	0.279798	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	157,950,794	31,598,219	189,549,013		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	157,950,794	31,598,219	189,549,013		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-2011	Period: From 01/01/2018 To 06/30/2018	Worksheet C Part I Date/Time Prepared: 11/28/2018 1:32 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital PPS
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.281534		50.00
53.00	05300 ANESTHESIOLOGY	0.014951		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.408150		54.00
56.00	05600 RADIOISOTOPE	0.506298		56.00
57.00	05700 CT SCAN	0.055314		57.00
57.01	03630 ULTRA SOUND	0.080034		57.01
58.00	05800 MRI	0.000000		58.00
60.00	06000 LABORATORY	0.158183		60.00
65.00	06500 RESPIRATORY THERAPY	0.091041		65.00
66.00	06600 PHYSICAL THERAPY	0.355319		66.00
69.00	06900 ELECTROCARDIOLOGY	0.106060		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.246736		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.324368		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.170100		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.130299		73.00
74.00	07400 RENAL DIALYSIS	0.141457		74.00
76.00	03950 SUBSTANCE ABUSE	0.665232		76.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.168957		76.98
76.99	07699 LI THOTRI PSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
90.02	09001 WOMENS DIAGNOSTIC CENTER	0.279798		90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

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

Provider CCN: 14-2011

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

Worksheet C Part II Date/Time Prepared: 11/28/2018 1:32 pm

Cost Center Description		Title XIX			Hospital	PPS		
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,846,637	492,721	2,353,916	0	0	50.00
53.00	05300	ANESTHESIOLOGY	28,847	3,037	25,810	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,040,395	134,242	906,153	0	0	54.00
56.00	05600	RADIOISOTOPE	115,609	21,908	93,701	0	0	56.00
57.00	05700	CT SCAN	127,589	10,509	117,080	0	0	57.00
57.01	03630	ULTRA SOUND	144,341	13,641	130,700	0	0	57.01
58.00	05800	MRI	5,575	120	5,455	0	0	58.00
60.00	06000	LABORATORY	2,291,361	135,812	2,155,549	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,986,651	57,690	2,928,961	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,546,882	220,862	2,326,020	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	124,127	24,062	100,065	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	352,023	52,360	299,663	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,017,398	94,728	1,922,670	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	270,183	11,307	258,876	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,699,530	117,335	3,582,195	0	0	73.00
74.00	07400	RENAL DIALYSIS	528,196	13,101	515,095	0	0	74.00
76.00	03950	SUBSTANCE ABUSE	1,102,530	153,209	949,321	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	725,480	23,644	701,836	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	159,234	56,227	103,007	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	202,167	47,037	155,130	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	21,314,755	1,683,552	19,631,203	0	0	200.00
201.00		Less Observation Beds	0	0	0	0	0	201.00
202.00		Total (line 200 minus line 201)	21,314,755	1,683,552	19,631,203	0	0	202.00

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

Provider CCN: 14-2011

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

Worksheet C
Part II
Date/Time Prepared:
11/28/2018 1:32 pm

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	PPS
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2,846,637	10,111,157	0.281534		50.00
53.00	05300 ANESTHESIOLOGY	28,847	1,929,375	0.014951		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,040,395	2,549,052	0.408150		54.00
56.00	05600 RADIOISOTOPE	115,609	228,342	0.506298		56.00
57.00	05700 CT SCAN	127,589	2,306,645	0.055314		57.00
57.01	03630 ULTRASOUND	144,341	1,803,493	0.080034		57.01
58.00	05800 MRI	5,575	0	0.000000		58.00
60.00	06000 LABORATORY	2,291,361	14,485,503	0.158183		60.00
65.00	06500 RESPIRATORY THERAPY	2,986,651	32,805,580	0.091041		65.00
66.00	06600 PHYSICAL THERAPY	2,546,882	7,167,884	0.355319		66.00
69.00	06900 ELECTROCARDIOLOGY	124,127	1,170,348	0.106060		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	352,023	1,426,722	0.246736		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2,017,398	6,219,479	0.324368		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	270,183	1,588,379	0.170100		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,699,530	28,392,680	0.130299		73.00
74.00	07400 RENAL DIALYSIS	528,196	3,733,956	0.141457		74.00
76.00	03950 SUBSTANCE ABUSE	1,102,530	1,657,361	0.665232		76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	725,480	4,293,870	0.168957		76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	159,234	0	0.000000		90.00
90.02	09001 WOMENS DIAGNOSTIC CENTER	202,167	722,545	0.279798		90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000		92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (sum of lines 50 thru 199)	21,314,755	122,592,371			200.00
201.00	Less Observation Beds	0	0			201.00
202.00	Total (line 200 minus line 201)	21,314,755	122,592,371			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-2011		Period: From 01/01/2018 To 06/30/2018		Worksheet D Part I Date/Time Prepared: 11/28/2018 1:32 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	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	1,018,258	0	1,018,258	14,209	71.66	30.00
31.00	INTENSIVE CARE UNIT	101,092		101,092	986	102.53	31.00
200.00	Total (lines 30 through 199)	1,119,350		1,119,350	15,195		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	6,125	438,918				
31.00	INTENSIVE CARE UNIT	318	32,605				
200.00	Total (lines 30 through 199)	6,443	471,523				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-2011	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part II Date/Time Prepared: 11/28/2018 1:32 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)	Hospital 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	492,721	10,111,157	0.048730	633,837	30,887	50.00
53.00	05300 ANESTHESIOLOGY	3,037	1,929,375	0.001574	132,531	209	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	134,242	2,549,052	0.052663	894,190	47,091	54.00
56.00	05600 RADIOISOTOPE	21,908	228,342	0.095944	28,648	2,749	56.00
57.00	05700 CT SCAN	10,509	2,306,645	0.004556	751,217	3,423	57.00
57.01	03630 ULTRASOUND	13,641	1,803,493	0.007564	170,347	1,289	57.01
58.00	05800 MRI	120	0	0.000000	0	0	58.00
60.00	06000 LABORATORY	135,812	14,485,503	0.009376	5,030,729	47,168	60.00
65.00	06500 RESPIRATORY THERAPY	57,690	32,805,580	0.001759	15,113,329	26,584	65.00
66.00	06600 PHYSICAL THERAPY	220,862	7,167,884	0.030813	2,511,397	77,384	66.00
69.00	06900 ELECTROCARDIOLOGY	24,062	1,170,348	0.020560	319,296	6,565	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	52,360	1,426,722	0.036700	19,045	699	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	94,728	6,219,479	0.015231	2,623,715	39,962	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	11,307	1,588,379	0.007119	167,270	1,191	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	117,335	28,392,680	0.004133	11,330,058	46,827	73.00
74.00	07400 RENAL DIALYSIS	13,101	3,733,956	0.003509	1,732,171	6,078	74.00
76.00	03950 SUBSTANCE ABUSE	153,209	1,657,361	0.092442	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	23,644	4,293,870	0.005506	284	2	76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	56,227	0	0.000000	0	0	90.00
90.02	09001 WOMENS DIAGNOSTIC CENTER	47,037	722,545	0.065099	0	0	90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
200.00	Total (lines 50 through 199)	1,683,552	122,592,371		41,458,064	338,108	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-2011		Period: From 01/01/2018 To 06/30/2018		Worksheet D Part III Date/Time Prepared: 11/28/2018 1:32 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
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
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	14,209	0.00	6,125	30.00
31.00	03100	INTENSIVE CARE UNIT			986	0.00	318	31.00
200.00		Total (lines 30 through 199)			15,195		6,443	200.00
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
			9.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0					30.00
31.00	03100	INTENSIVE CARE UNIT	0					31.00
200.00		Total (lines 30 through 199)	0					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-2011	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/28/2018 1:32 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	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
57.01	03630	ULTRASOUND	0	0	0	0	0	57.01
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	SUBSTANCE ABUSE	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-2011	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/28/2018 1:32 pm
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Cost Center Description		Title XVIII			Hospital	PPS		
		All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	10,111,157	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,929,375	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	2,549,052	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	228,342	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	2,306,645	0.000000	57.00
57.01	03630	ULTRA SOUND	0	0	0	1,803,493	0.000000	57.01
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	14,485,503	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	32,805,580	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,167,884	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,170,348	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,426,722	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	6,219,479	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,588,379	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	28,392,680	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,733,956	0.000000	74.00
76.00	03950	SUBSTANCE ABUSE	0	0	0	1,657,361	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	4,293,870	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	0	0	722,545	0.000000	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	122,592,371		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-2011	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/28/2018 1:32 pm
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Cost Center Description		Title XVIII				Hospital		
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PPS	
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	633,837	0	2,984,405	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	132,531	0	490,763	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	894,190	0	158,490	0	54.00
56.00	05600	RADIOLOGY-SOFT	0.000000	28,648	0	50,393	0	56.00
57.00	05700	CT SCAN	0.000000	751,217	0	305,412	0	57.00
57.01	03630	ULTRA SOUND	0.000000	170,347	0	222,965	0	57.01
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	5,030,729	0	476,236	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	15,113,329	0	151	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	2,511,397	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	319,296	0	135,523	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	19,045	0	223,956	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	2,623,715	0	337,617	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	167,270	0	457,471	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	11,330,058	0	914,294	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	1,732,171	0	444,960	0	74.00
76.00	03950	SUBSTANCE ABUSE	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	284	0	1,959,458	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0.000000	0	0	94,666	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		41,458,064	0	9,256,760	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-2011

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

Worksheet D
Part V
Date/Time Prepared:
11/28/2018 1:32 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	0.281534	2,984,405	0	26	840,211	50.00
53.00	05300	ANESTHESIOLOGY	0.014951	490,763	0	0	7,337	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.408150	158,490	0	0	64,688	54.00
56.00	05600	RADIOISOTOPE	0.506298	50,393	0	0	25,514	56.00
57.00	05700	CT SCAN	0.055314	305,412	0	9	16,894	57.00
57.01	03630	ULTRASOUND	0.080034	222,965	0	0	17,845	57.01
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.158183	476,236	0	0	75,332	60.00
65.00	06500	RESPIRATORY THERAPY	0.091041	151	0	0	14	65.00
66.00	06600	PHYSICAL THERAPY	0.355319	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.106060	135,523	0	0	14,374	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.246736	223,956	0	0	55,258	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.324368	337,617	0	0	109,512	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.170100	457,471	0	0	77,816	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.130299	914,294	0	1,204	119,132	73.00
74.00	07400	RENAL DIALYSIS	0.141457	444,960	0	0	62,943	74.00
76.00	03950	SUBSTANCE ABUSE	0.665232	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.168957	1,959,458	0	0	331,064	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0.279798	94,666	0	0	26,487	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Subtotal (see instructions)		9,256,760	0	1,239	1,844,421	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		9,256,760	0	1,239	1,844,421	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-2011	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part V Date/Time Prepared: 11/28/2018 1:32 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	7	50.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
57.01	03630 ULTRASOUND	0	0	57.01
58.00	05800 MRI	0	0	58.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	157	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03950 SUBSTANCE ABUSE	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
90.02	09001 WOMENS DIAGNOSTIC CENTER	0	0	90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00	Subtotal (see instructions)	0	164	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	0	164	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-2011		Period: From 01/01/2018 To 06/30/2018		Worksheet D Part I Date/Time Prepared: 11/28/2018 1:32 pm		
Cost Center Description		Title XIX		Hospital		PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	1,018,258	0	1,018,258	14,209	71.66	30.00	
31.00	INTENSIVE CARE UNIT	101,092		101,092	986	102.53	31.00	
200.00	Total (lines 30 through 199)	1,119,350		1,119,350	15,195		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	2,275	163,027					30.00
31.00	INTENSIVE CARE UNIT	172	17,635					31.00
200.00	Total (lines 30 through 199)	2,447	180,662					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-2011	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part II Date/Time Prepared: 11/28/2018 1:32 pm
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Cost Center Description		Title XIX			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	492,721	10,111,157	0.048730	45,784	2,231	50.00
53.00	05300	ANESTHESIOLOGY	3,037	1,929,375	0.001574	11,183	18	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	134,242	2,549,052	0.052663	134,446	7,080	54.00
56.00	05600	RADIOISOTOPE	21,908	228,342	0.095944	5,446	523	56.00
57.00	05700	CT SCAN	10,509	2,306,645	0.004556	205,225	935	57.00
57.01	03630	ULTRA SOUND	13,641	1,803,493	0.007564	70,196	531	57.01
58.00	05800	MRI	120	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	135,812	14,485,503	0.009376	1,233,992	11,570	60.00
65.00	06500	RESPIRATORY THERAPY	57,690	32,805,580	0.001759	1,977,157	3,478	65.00
66.00	06600	PHYSICAL THERAPY	220,862	7,167,884	0.030813	666,476	20,536	66.00
69.00	06900	ELECTROCARDIOLOGY	24,062	1,170,348	0.020560	87,107	1,791	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	52,360	1,426,722	0.036700	5,777	212	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	94,728	6,219,479	0.015231	1,052,041	16,024	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,307	1,588,379	0.007119	6,902	49	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	117,335	28,392,680	0.004133	4,311,442	17,819	73.00
74.00	07400	RENAL DIALYSIS	13,101	3,733,956	0.003509	70,782	248	74.00
76.00	03950	SUBSTANCE ABUSE	153,209	1,657,361	0.092442	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	23,644	4,293,870	0.005506	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	56,227	0	0.000000	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	47,037	722,545	0.065099	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	1,683,552	122,592,371		9,883,956	83,045	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-2011		Period: From 01/01/2018 To 06/30/2018		Worksheet D Part III Date/Time Prepared: 11/28/2018 1:32 pm		
Cost Center Description			Title XIX		Hospital		PPS		
			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
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	14,209	0.00	2,275	30.00	
31.00	03100	INTENSIVE CARE UNIT			986	0.00	172	31.00	
200.00		Total (lines 30 through 199)			15,195		2,447	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-2011

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

Worksheet D
Part IV
Date/Time Prepared:
11/28/2018 1:32 pm

Cost Center Description		Title XIX			Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
		1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
57.01	03630	ULTRASOUND	0	0	0	0	0	57.01
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	SUBSTANCE ABUSE	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-2011

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

Worksheet D
Part IV
Date/Time Prepared:
11/28/2018 1:32 pm

Cost Center Description		Title XIX			Hospital	PPS		
		All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Total Outpatient Cost (sum of col 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	10,111,157	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,929,375	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	2,549,052	0.000000	54.00
56.00	05600	RADIO SOTOPE	0	0	0	228,342	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	2,306,645	0.000000	57.00
57.01	03630	ULTRA SOUND	0	0	0	1,803,493	0.000000	57.01
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	14,485,503	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	32,805,580	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,167,884	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,170,348	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,426,722	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	6,219,479	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,588,379	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	28,392,680	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,733,956	0.000000	74.00
76.00	03950	SUBSTANCE ABUSE	0	0	0	1,657,361	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	4,293,870	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	0	0	722,545	0.000000	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	122,592,371		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-2011	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/28/2018 1:32 pm
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Cost Center Description		Title XIX			Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	45,784	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	11,183	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	134,446	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0.000000	5,446	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	205,225	0	0	0	57.00
57.01	03630 ULTRA SOUND	0.000000	70,196	0	0	0	57.01
58.00	05800 MRI	0.000000	0	0	0	0	58.00
60.00	06000 LABORATORY	0.000000	1,233,992	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	1,977,157	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	666,476	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	87,107	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	5,777	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,052,041	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	6,902	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	4,311,442	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	70,782	0	0	0	74.00
76.00	03950 SUBSTANCE ABUSE	0.000000	0	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.02	09001 WOMENS DIAGNOSTIC CENTER	0.000000	0	0	0	0	90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00	Total (lines 50 through 199)		9,883,956	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-2011	Period: From 01/01/2018 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/28/2018 1:32 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)		14,209	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		14,209	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)		14,209	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		6,125	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)		14,298,617	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)		14,298,617	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)		14,298,617	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,006.31	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		6,163,649	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		6,163,649	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-2011	Period: From 01/01/2018 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/28/2018 1:32 pm		
Cost Center Description			Title XVIII		Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	2,019,310	986	2,047.98	318	651,258	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)					6,318,576	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					13,133,483	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)					471,523	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					338,108	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					809,631	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					12,323,852	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-2011		Period: From 01/01/2018 To 06/30/2018		Worksheet D-1 Date/Time Prepared: 11/28/2018 1:32 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,018,258	14,298,617	0.071214	0	0	90.00
91.00	Nursing School cost	0	14,298,617	0.000000	0	0	91.00
92.00	Allied health cost	0	14,298,617	0.000000	0	0	92.00
93.00	All other Medical Education	0	14,298,617	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-2011	Period: From 01/01/2018 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/28/2018 1:32 pm
Cost Center Description		Title XIX	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		14,209	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		14,209	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)		14,209	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,275	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)		14,298,617	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)		14,298,617	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)		14,298,617	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,006.31	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,289,355	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,289,355	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-2011	Period: From 01/01/2018 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/28/2018 1:32 pm		
Cost Center Description			Title XIX		Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	2,019,310	986	2,047.98	172	352,253	43.00	
44.00	CORONARY CARE UNIT					44.00	
45.00	BURN INTENSIVE CARE UNIT					45.00	
46.00	SURGICAL INTENSIVE CARE UNIT					46.00	
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00	
Cost Center Description							
					1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,624,545	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,266,153	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)					180,662	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					83,045	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					263,707	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					4,002,446	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-2011		Period: From 01/01/2018 To 06/30/2018		Worksheet D-1 Date/Time Prepared: 11/28/2018 1:32 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,018,258	14,298,617	0.071214	0	0	90.00
91.00	Nursing School cost	0	14,298,617	0.000000	0	0	91.00
92.00	Allied health cost	0	14,298,617	0.000000	0	0	92.00
93.00	All other Medical Education	0	14,298,617	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-2011	Period: From 01/01/2018 To 06/30/2018	Worksheet D-3 Date/Time Prepared: 11/28/2018 1:32 pm
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Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		26,592,500		30.00
31.00	03100 INTENSIVE CARE UNIT		2,732,289		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.281534	633,837	178,447	50.00
53.00	05300 ANESTHESIOLOGY	0.014951	132,531	1,981	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.408150	894,190	364,964	54.00
56.00	05600 RADIOISOTOPE	0.506298	28,648	14,504	56.00
57.00	05700 CT SCAN	0.055314	751,217	41,553	57.00
57.01	03630 ULTRASOUND	0.080034	170,347	13,634	57.01
58.00	05800 MRI	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.158183	5,030,729	795,776	60.00
65.00	06500 RESPIRATORY THERAPY	0.091041	15,113,329	1,375,933	65.00
66.00	06600 PHYSICAL THERAPY	0.355319	2,511,397	892,347	66.00
69.00	06900 ELECTROCARDIOLOGY	0.106060	319,296	33,865	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.246736	19,045	4,699	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.324368	2,623,715	851,049	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.170100	167,270	28,453	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.130299	11,330,058	1,476,295	73.00
74.00	07400 RENAL DIALYSIS	0.141457	1,732,171	245,028	74.00
76.00	03950 SUBSTANCE ABUSE	0.665232	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.168957	284	48	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.02	09001 WOMENS DIAGNOSTIC CENTER	0.279798	0	0	90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		41,458,064	6,318,576	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)		41,458,064		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-2011	Period: From 01/01/2018 To 06/30/2018	Worksheet D-3 Date/Time Prepared: 11/28/2018 1:32 pm
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Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		7,441,237		30.00
31.00	03100 INTENSIVE CARE UNIT		230,470		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.281534	45,784	12,890	50.00
53.00	05300 ANESTHESIOLOGY	0.014951	11,183	167	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.408150	134,446	54,874	54.00
56.00	05600 RADIOISOTOPE	0.506298	5,446	2,757	56.00
57.00	05700 CT SCAN	0.055314	205,225	11,352	57.00
57.01	03630 ULTRASOUND	0.080034	70,196	5,618	57.01
58.00	05800 MRI	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.158183	1,233,992	195,197	60.00
65.00	06500 RESPIRATORY THERAPY	0.091041	1,977,157	180,002	65.00
66.00	06600 PHYSICAL THERAPY	0.355319	666,476	236,812	66.00
69.00	06900 ELECTROCARDIOLOGY	0.106060	87,107	9,239	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.246736	5,777	1,425	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.324368	1,052,041	341,248	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.170100	6,902	1,174	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.130299	4,311,442	561,777	73.00
74.00	07400 RENAL DIALYSIS	0.141457	70,782	10,013	74.00
76.00	03950 SUBSTANCE ABUSE	0.665232	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.168957	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.02	09001 WOMENS DIAGNOSTIC CENTER	0.279798	0	0	90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		9,883,956	1,624,545	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)		9,883,956		202.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-2011

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/28/2018 1:32 pm

		Title XVIII			Hospital		PPS	
	W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)		
	0	1.00	2.00	3.00	4.00	5.00		
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	10,188		10,188	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0	0	0	0	0	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	0	0	42,497	0	42,497	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	0	11.01
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	0	0	0	0	0	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	0	0	0	0	0	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	0	0	0	0	0	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ acquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	0	0	0	19.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-2011

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/28/2018 1:32 pm

		Title XVIII			Hospital		PPS	
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	0	0	0	0	0	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	0	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	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	0	0	0	0	0	26.00
		W/S E, Part A, line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 14-2011		Period: From 01/01/2018 To 06/30/2018		Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/28/2018 1:32 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 (cols. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	10,188		10,188	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0		0	0	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	0	42,497	0	42,497	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	11.01
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	0	0	0	0	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	0	0	0	0	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	0	0	0	0	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			0	0	0	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-2011

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

Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/28/2018 1:32 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	0	0	0	0	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	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	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	0	0	0	0	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.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-2011	Period: From 01/01/2018 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/28/2018 1:32 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		164	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		1,844,421	2.00
3.00	OPPS payments		1,273,604	3.00
4.00	Outlier payment (see instructions)		54,697	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)		164	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		1,239	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		1,239	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		1,239	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		1,075	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)		164	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		1,328,301	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		261,891	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		1,066,574	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		109	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		1,066,683	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,066,683	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)		4,878	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		3,171	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,179	36.00
37.00	Subtotal (see instructions)		1,069,854	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)		1,069,854	40.00
40.01	Sequestration adjustment (see instructions)		21,397	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		1,045,224	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		3,233	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-2011

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

Worksheet E-1
Part I
Date/Time Prepared:
11/28/2018 1:32 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		11,163,757		1,045,224		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)		11,163,757		1,045,224		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		43,902		3,233		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		11,207,659		1,048,457		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-2011	Period: From 01/01/2018 To 06/30/2018	Worksheet E-1 Part II Date/Time Prepared: 11/28/2018 1:32 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-2011	Period: From 01/01/2018 To 06/30/2018	Worksheet E-3 Part IV Date/Time Prepared: 11/28/2018 1:32 pm
		Title XVIII	Hospital	PPS
				1.00
PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)			11,048,955 1.00
1.01	Full standard payment amount			9,339,389 1.01
1.02	Short stay outlier standard payment amount			1,558,831 1.02
1.03	Site neutral payment amount - Cost			44,354 1.03
1.04	Site neutral payment amount - IPPS comparable			106,381 1.04
2.00	Outlier Payments			1,108,057 2.00
3.00	Total PPS Payments (sum of lines 1 and 2)			12,157,012 3.00
4.00	Nursing and Allied Health Managed Care payments (see instructions)			0 4.00
5.00	Organ acquisition (DO NOT USE THIS LINE)			0 5.00
6.00	Cost of physicians' services in a teaching hospital (see instructions)			0 6.00
7.00	Subtotal (see instructions)			12,157,012 7.00
8.00	Primary payer payments			0 8.00
9.00	Subtotal (line 7 less line 8)			12,157,012 9.00
10.00	Deductibles			26,776 10.00
11.00	Subtotal (line 9 minus line 10)			12,130,236 11.00
12.00	Coinsurance			738,647 12.00
13.00	Subtotal (line 11 minus line 12)			11,391,589 13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			67,724 14.00
15.00	Adjusted reimbursable bad debts (see instructions)			44,021 15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			15,792 16.00
17.00	Subtotal (sum of lines 13 and 15)			11,435,610 17.00
18.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			777 18.00
19.00	Other pass through costs (see instructions)			0 19.00
20.00	Outlier payments reconciliation			0 20.00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 21.00
21.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 21.50
21.99	Demonstration payment adjustment amount before sequestration			0 21.99
22.00	Total amount payable to the provider (see instructions)			11,436,387 22.00
22.01	Sequestration adjustment (see instructions)			228,728 22.01
22.02	Demonstration payment adjustment amount after sequestration			0 22.02
23.00	Interim payments			11,163,757 23.00
24.00	Tentative settlement (for contractor use only)			0 24.00
25.00	Balance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24)			43,902 25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 26.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions)			1,108,057 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money (see instructions)			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-2011	Period: From 01/01/2018 To 06/30/2018	Worksheet E-3 Part VII Date/Time Prepared: 11/28/2018 1:32 pm	
		Title XIX	Hospital	PPS	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		7,441,237		8.00
9.00	Ancillary service charges		9,883,956	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		17,325,193	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		17,325,193	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		17,325,193	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-2011	Period: From 01/01/2018 To 06/30/2018	Worksheet E-4 Date/Time Prepared: 11/28/2018 1:32 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.			1.35	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)			0.59	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))			-0.76	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)			0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.12	6.00
7.00	Enter the lesser of line 5 or line 6			0.00	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.	0.03	0.09	0.12	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	0.00	0.00	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	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.03	0.02		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.01	0.01		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.01	0.01		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	0.01	0.01		17.00
18.00	Per resident amount	103,517.72	105,402.54		18.00
19.00	Approved amount for resident costs	1,035	1,054	2,089	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)			0.12	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)			2,089	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	6,443	0		26.00
27.00	Total Inpatient Days (see instructions)	15,195	15,195		27.00
28.00	Ratio of inpatient days to total inpatient days	0.424021	0.000000		28.00
29.00	Program direct GME amount	886	0		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		0		30.00
31.00	Net Program direct GME amount			886	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-2011	Period: From 01/01/2018 To 06/30/2018	Worksheet E-4 Date/Time Prepared: 11/28/2018 1:32 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)		3,733,956	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)		13,133,483	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)		13,133,483	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		1,844,585	42.00
43.00	Primary payer payments (see instructions)		0	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		1,844,585	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		14,978,068	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.876848	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.123152	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		886	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		777	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		109	50.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) Provider CCN: 14-2011 Period: From 01/01/2018 To 06/30/2018 Worksheet G Date/Time Prepared: 11/28/2018 1:32 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	2,009	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	67,514,451	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-49,751,019	0	0	0	6.00
7.00	Inventory	1,223,328	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	1,342,174	0	0	0	9.00
10.00	Due from other funds	-254,736	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	20,076,207	0	0	0	11.00
FIXED ASSETS						
12.00	Land	6,320,000	0	0	0	12.00
13.00	Land improvements	397,500	0	0	0	13.00
14.00	Accumulated depreciation	-8,417	0	0	0	14.00
15.00	Buildings	21,250,087	0	0	0	15.00
16.00	Accumulated depreciation	-362,092	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	1,740,788	0	0	0	19.00
20.00	Accumulated depreciation	-132,047	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	3,173,876	0	0	0	23.00
24.00	Accumulated depreciation	-238,351	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)	32,141,344	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	1,374,678	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)	1,374,678	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	53,592,229	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	5,588	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	9,122,095	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,127,683	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)	9,127,683	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	44,464,546	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	44,464,546	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	53,592,229	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-2011

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

Worksheet G-1

Date/Time Prepared:
11/28/2018 1:32 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		45,246,190		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-781,644			2.00
3.00	Total (sum of line 1 and line 2)		44,464,546		0	3.00
4.00	RECONCILING ITEM	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)		44,464,546		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		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		44,464,546		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	RECONCILING ITEM		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			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: 14-2011

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/28/2018 1:32 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	61,360,129		61,360,129	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)	61,360,129		61,360,129	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,946,006		5,946,006	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)	5,946,006		5,946,006	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	67,306,135		67,306,135	17.00
18.00	Ancillary services	91,089,620	30,429,934	121,519,554	18.00
19.00	Outpatient services	0	723,325	723,325	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	CLINIC OP REVENUE	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	158,395,755	31,153,259	189,549,014	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		36,136,812		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)		36,136,812		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-2011

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

Worksheet G-3

Date/Time Prepared:
11/28/2018 1:32 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	189,549,014	1.00
2.00	Less contractual allowances and discounts on patients' accounts	155,349,724	2.00
3.00	Net patient revenues (line 1 minus line 2)	34,199,290	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	36,136,812	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,937,522	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	95	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	116,930	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	INTERCOMPANY RENTAL	564,111	24.00
24.01	NET ASSETS RELEASED	3,658	24.01
24.02	OTHER REVENUE	471,084	24.02
25.00	Total other income (sum of lines 6-24)	1,155,878	25.00
26.00	Total (line 5 plus line 25)	-781,644	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)	-781,644	29.00