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: 14-0100	Period: From 07/01/2017 To 06/30/2018	Worksheet S Parts I-III Date/Time Prepared: 11/28/2018 7:11 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/28/2018 Time: 7:11 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] 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. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] 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 MIDWESTERN REGIONAL MEDICAL CENTER (14-0100) for the cost reporting period beginning 07/01/2017 and ending 06/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	17,456	184,517	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	17,456	184,517	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: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/28/2018 10:46 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2501 EMMAUS AVENUE	PO Box:			1.00
2.00	City: ZION	State: IL	Zip Code: 60099	County: LAKE	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	MIDWESTERN REGIONAL MEDICAL CENTER	140100	29404	1	07/01/1967	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2017	06/30/2018	20.00
21.00	Type of Control (see instructions)	4		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	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	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		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/28/2018 10:46 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			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)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	Y	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.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				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)				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2018 10:46 am

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2018 10:46 am

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0100	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/28/2018 10:46 am

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? 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	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/28/2018 10:46 am

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	2,403,355	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H130	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2018 10:46 am

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: CTCA	Contractor's Name: FCSO	Contractor's Number: 09001	141.00
142.00	Street: 5900 BROKEN SOUND PARKWAY NW	PO Box:		142.00
143.00	City: BOCA RATON	State: FL	Zip Code: 33487	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	N	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.			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	
	Multicampus		
165.00	Is this hospital part of a Multicampus 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.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	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)	0.99	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2017	06/30/2018	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	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II | Date/Time Prepared: 11/28/2018 10:46 am

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	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	10/24/2018	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.	Y			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.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	11/16/2018	Y	11/16/2018	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: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II | Date/Time Prepared: 11/28/2018 10:46 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	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.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	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.				N	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				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	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.				N	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.				N	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.				N	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.				N	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.	CORY		RUTLEDGE		41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN LLP				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	612-376-4500		CORY.RUTLEDGE@CLACONNECT.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0100	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/28/2018 10:46 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PRINCIPAL		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: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I Date/Time Prepared: 11/28/2018 10:46 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	49	17,885	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)		49	17,885	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	24	8,760	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	34.00	0	0	0.00	0	11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		73	26,645	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)		73				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: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/28/2018 10:46 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,247	3	4,025			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			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,247	3	4,025			7.00
8.00	INTENSIVE CARE UNIT	330	13	4,540			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT	0	0	0			11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,577	16	8,565	0.00	911.78	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	911.78	27.00
28.00	Observation Bed Days		4	888			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/28/2018 10:46 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
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	283	18	1,555	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	283	18	1,555	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part II | Date/Time Prepared: 11/28/2018 10:46 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	60,769,082	0	60,769,082	1,896,498.90	32.04	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		5,359,952	31,316	5,391,268	222,053.65	24.28	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		276,017	0	276,017	4,566.75	60.44	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		19,675,118	0	19,675,118	410,627.45	47.91	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		18,193,664	0	18,193,664			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		2,412,721	0	2,412,721			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		10,430,702	0	10,430,702			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	2,919,665	-2,202,503	717,162	15,462.90	46.38	26.00
27.00	Administrative & General	5.00	5,226,497	913,559	6,140,056	183,265.65	33.50	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part II | Date/Time Prepared: 11/28/2018 10:46 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		1,813,867	0	1,813,867	3,384.87	535.87	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,791,415	47,707	1,839,122	70,716.30	26.01	30.00
31.00	Laundry & Linen Service	8.00	38,145	0	38,145	2,213.45	17.23	31.00
32.00	Housekeeping	9.00	1,536,689	40,923	1,577,612	104,056.65	15.16	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,348,679	-1,223,790	124,889	7,466.87	16.73	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	135,901	1,263,325	1,399,226	84,858.50	16.49	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,057,182	28,153	1,085,335	23,106.92	46.97	38.00
39.00	Central Services and Supply	14.00	2,577	69	2,646	833.25	3.18	39.00
40.00	Pharmacy	15.00	2,690,647	71,654	2,762,301	71,394.43	38.69	40.00
41.00	Medical Records & Medical Records Library	16.00	1,420,143	37,819	1,457,962	46,271.93	31.51	41.00
42.00	Social Service	17.00	522,798	13,922	536,720	19,664.55	27.29	42.00
43.00	Other General Service	18.00	1,760,273	46,877	1,807,150	47,628.01	37.94	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part III Date/Time Prepared: 11/28/2018 10:46 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		62,582,949	0	62,582,949	1,899,883.77	32.94	1.00
2.00	Excluded area salaries (see instructions)		5,359,952	31,316	5,391,268	222,053.65	24.28	2.00
3.00	Subtotal salaries (line 1 minus line 2)		57,222,997	-31,316	57,191,681	1,677,830.12	34.09	3.00
4.00	Subtotal other wages & related costs (see inst.)		19,951,135	0	19,951,135	415,194.20	48.05	4.00
5.00	Subtotal wage-related costs (see inst.)		28,624,366	0	28,624,366	0.00	50.05	5.00
6.00	Total (sum of lines 3 thru 5)		105,798,498	-31,316	105,767,182	2,093,024.32	50.53	6.00
7.00	Total overhead cost (see instructions)		22,264,478	-962,285	21,302,193	680,324.28	31.31	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part IV Date/Time Prepared: 11/28/2018 10:46 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,665,209	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	8,814,856	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	2,165,905	9.00
10.00	Dental, Hearing and Vision Plan	943,787	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	114,670	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	524,762	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	748,112	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	17,484	14.00
15.00	'Workers' Compensation Insurance	475,977	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	4,175,762	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	576,293	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	383,567	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	20,606,384	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part V Date/Time Prepared: 11/28/2018 10:46 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	276,017	20,606,384	1.00
2.00	Hospital	276,017	20,606,384	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-10 | Date/Time Prepared: 11/28/2018 10:46 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.236863	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	732,065	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	2,328,990	6.00
7.00	Medicaid cost (line 1 times line 6)	551,652	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	0	47,398,605	47,398,605	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	0	47,398,605	47,398,605	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	0	47,398,605	47,398,605	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	439,661	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	285,779	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	439,661	27.01
28.00	Non-Medicare bad debt expense (see instructions)	0	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	153,882	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	47,552,487	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	47,552,487	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/28/2018 10:46 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		21,178,294	21,178,294	-240,975	20,937,319	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		11,329,703	11,329,703	0	11,329,703	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,919,665	13,678,433	16,598,098	-1,618,870	14,979,228	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,226,497	172,520,821	177,747,318	43,948	177,791,266	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,791,415	4,675,038	6,466,453	47,707	6,514,160	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	38,145	368,692	406,837	0	406,837	8.00
9.00	00900	HOUSEKEEPING	1,536,689	657,736	2,194,425	40,923	2,235,348	9.00
10.00	01000	DIETARY	1,348,679	1,951,800	3,300,479	-2,999,540	300,939	10.00
11.00	01100	CAFETERIA	135,901	166,374	302,275	3,039,075	3,341,350	11.00
13.00	01300	NURSING ADMINISTRATION	1,057,182	303,763	1,360,945	28,153	1,389,098	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,577	247,337	249,914	69	249,983	14.00
15.00	01500	PHARMACY	2,690,647	526,629	3,217,276	71,654	3,288,930	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,420,143	187,833	1,607,976	37,819	1,645,795	16.00
17.00	01700	SOCIAL SERVICE	522,798	287,507	810,305	13,922	824,227	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	1,760,273	324,921	2,085,194	46,877	2,132,071	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,199,392	707,183	4,906,575	111,833	5,018,408	30.00
31.00	03100	INTENSIVE CARE UNIT	3,487,281	570,026	4,057,307	92,869	4,150,176	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,732,826	1,654,362	6,387,188	126,038	6,513,226	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,671,924	1,753,281	4,425,205	71,155	4,496,360	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,764,631	3,387,936	5,152,567	46,993	5,199,560	55.00
56.00	05600	RADIOISOTOPE	379,731	108,973	488,704	10,112	498,816	56.00
57.00	05700	CT SCAN	511,717	325,393	837,110	13,627	850,737	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	434,677	416,154	850,831	11,576	862,407	58.00
60.00	06000	LABORATORY	2,299,698	3,499,777	5,799,475	61,243	5,860,718	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	947,616	947,616	0	947,616	63.00
64.00	06400	INTRAVENOUS THERAPY	1,683,577	240,190	1,923,767	44,835	1,968,602	64.00
65.00	06500	RESPIRATORY THERAPY	937,781	376,415	1,314,196	24,974	1,339,170	65.00
66.00	06600	PHYSICAL THERAPY	1,234,586	197,378	1,431,964	32,878	1,464,842	66.00
69.00	06900	ELECTROCARDIOLOGY	406,047	106,680	512,727	10,813	523,540	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	13,440,103	13,440,103	0	13,440,103	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	85,806,729	85,806,729	0	85,806,729	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	463,089	93,356	556,445	12,332	568,777	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	8,994,311	1,276,439	10,270,750	239,525	10,510,275	90.00
91.00	09100	EMERGENCY	757,251	200,469	957,720	20,166	977,886	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		551,048	551,048	-338,617	212,431	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	55,409,130	344,064,389	399,473,519	-896,886	398,576,633	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	-782	-782	0	-782	190.00
191.00	19100	RESEARCH	0	25	25	0	25	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	5,359,952	25,030,361	30,390,313	896,886	31,287,199	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	60,769,082	369,093,993	429,863,075	0	429,863,075	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/28/2018 10:46 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-4,771,420	16,165,899		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,122,636	14,452,339		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-107,656	14,871,572		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-116,097,449	61,693,817		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00
7.00	00700	OPERATION OF PLANT	0	6,514,160		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	406,837		8.00
9.00	00900	HOUSEKEEPING	0	2,235,348		9.00
10.00	01000	DIETARY	-291,636	9,303		10.00
11.00	01100	CAFETERIA	-2,704,018	637,332		11.00
13.00	01300	NURSING ADMINISTRATION	-9	1,389,089		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	249,983		14.00
15.00	01500	PHARMACY	-12	3,288,918		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,048	1,644,747		16.00
17.00	01700	SOCIAL SERVICE	4,026	828,253		17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	-34,101	2,097,970		18.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-32	5,018,376		30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,150,176		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0		34.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	6,513,226		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,496,360		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-39	5,199,521		55.00
56.00	05600	RADIOISOTOPE	0	498,816		56.00
57.00	05700	CT SCAN	0	850,737		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	862,407		58.00
60.00	06000	LABORATORY	0	5,860,718		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	947,616		63.00
64.00	06400	INTRAVENOUS THERAPY	-28,846	1,939,756		64.00
65.00	06500	RESPIRATORY THERAPY	0	1,339,170		65.00
66.00	06600	PHYSICAL THERAPY	-46,060	1,418,782		66.00
69.00	06900	ELECTROCARDIOLOGY	0	523,540		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	13,440,103		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	85,806,729		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.01	03951	HOSPITAL NUTRITION	-10	568,767		76.01
76.02	03952	PAIN MANAGEMENT	0	0		76.02
76.03	03954	INFUSION CENTER	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	10,510,275		90.00
91.00	09100	EMERGENCY	0	977,886		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	-212,431	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-121,168,105	277,408,528		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	-782		190.00
191.00	19100	RESEARCH	0	25		191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	31,287,199		194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-121,168,105	308,694,970		200.00

RECLASSIFICATIONS | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/28/2018 10:46 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RECLASS CAFETERIA				
1.00	CAFETERIA	11.00	1,259,706	1,775,750	1.00
	0		1,259,706	1,775,750	
	B - EMPLOYEE BONUS				
1.00	ADMINISTRATIVE & GENERAL	5.00	769,429	0	1.00
2.00	OPERATION OF PLANT	7.00	47,707	0	2.00
3.00	HOUSEKEEPING	9.00	40,923	0	3.00
4.00	DIETARY	10.00	35,916	0	4.00
5.00	CAFETERIA	11.00	3,619	0	5.00
6.00	NURSING ADMINISTRATION	13.00	28,153	0	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	69	0	7.00
8.00	PHARMACY	15.00	71,654	0	8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	37,819	0	9.00
10.00	SOCIAL SERVICE	17.00	13,922	0	10.00
11.00	OTHER GENERAL SERVICE (SPECIFY)	18.00	46,877	0	11.00
12.00	ADULTS & PEDIATRICS	30.00	111,833	0	12.00
13.00	INTENSIVE CARE UNIT	31.00	92,869	0	13.00
14.00	OPERATING ROOM	50.00	126,038	0	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	71,155	0	15.00
16.00	RADIOLOGY-THERAPEUTIC	55.00	46,993	0	16.00
17.00	RADIOISOTOPE	56.00	10,112	0	17.00
18.00	CT SCAN	57.00	13,627	0	18.00
19.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	11,576	0	19.00
20.00	LABORATORY	60.00	61,243	0	20.00
21.00	INTRAVENOUS THERAPY	64.00	44,835	0	21.00
22.00	RESPIRATORY THERAPY	65.00	24,974	0	22.00
23.00	PHYSICAL THERAPY	66.00	32,878	0	23.00
24.00	ELECTROCARDIOLOGY	69.00	10,813	0	24.00
25.00	HOSPITAL NUTRITION	76.01	12,332	0	25.00
27.00	CLINIC	90.00	239,525	0	27.00
28.00	EMERGENCY	91.00	20,166	0	28.00
31.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	175,446	0	31.00
	0		2,202,503	0	
	C - PROPERTY TAX				
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	0	976,179	1.00
	0		0	976,179	
	D - TRAVEL/SCHEDULING				
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	31,420	5,930	1.00
	0		31,420	5,930	
	E - GUEST SERVICES				
1.00		0.00	0	0	1.00
	0		0	0	
	F - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	338,617	1.00
	0		0	338,617	
	G - INSURANCE EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	406,216	1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	583,633	2.00
	0		0	989,849	
	H - TRANSPORTATION				
1.00	ADMINISTRATIVE & GENERAL	5.00	175,550	126,168	1.00
	0		175,550	126,168	
	I - GUEST ACCOMODATIONS DEPRECIATION				
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	0	9,629	1.00
	TOTALS		0	9,629	
500.00	Grand Total: Increases		3,669,179	4,222,122	500.00

RECLASSIFICATIONS | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/28/2018 10:46 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS CAFETERIA						
1.00	DIETARY	10.00	1,259,706	1,775,750	0		1.00
	0		1,259,706	1,775,750			
	B - EMPLOYEE BONUS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	2,202,503	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
27.00		0.00	0	0	0		27.00
28.00		0.00	0	0	0		28.00
31.00		0.00	0	0	0		31.00
	0		2,202,503	0			
	C - PROPERTY TAX						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	976,179	13		1.00
	0		0	976,179			
	D - TRAVEL/SCHEDULING						
1.00	ADMINISTRATIVE & GENERAL	5.00	31,420	5,930	0		1.00
	0		31,420	5,930			
	E - GUEST SERVICES						
1.00		0.00	0	0	0		1.00
	0		0	0			
	F - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	338,617	11		1.00
	0		0	338,617			
	G - INSURANCE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	989,849	12		1.00
2.00		0.00	0	0	0		2.00
	0		0	989,849			
	H - TRANSPORTATION						
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	175,550	126,168	0		1.00
	0		175,550	126,168			
	I - GUEST ACCOMODATIONS DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	9,629	9		1.00
	TOTALS		0	9,629			
500.00	Grand Total: Decreases		3,669,179	4,222,122			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part I | Date/Time Prepared: 11/28/2018 10:46 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	1,126,605	0	0	0	0	2.00
3.00	Buildings and Fixtures	35,861,654	3,827,832	0	3,827,832	3,322,117	3.00
4.00	Building Improvements	165,332,522	2,766,451	0	2,766,451	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	92,739,566	5,777,428	0	5,777,428	482,863	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	295,060,347	12,371,711	0	12,371,711	3,804,980	8.00
9.00	Reconciling Items	13,822,581	3,827,832	0	3,827,832	3,322,117	9.00
10.00	Total (line 8 minus line 9)	281,237,766	8,543,879	0	8,543,879	482,863	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	1,126,605	0	2.00
3.00	Buildings and Fixtures	36,367,369	0	3.00
4.00	Building Improvements	168,098,973	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	98,034,131	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	303,627,078	0	8.00
9.00	Reconciling Items	14,328,296	0	9.00
10.00	Total (line 8 minus line 9)	289,298,782	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part II Date/Time Prepared: 11/28/2018 10:46 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	10,754,054	0	0	0	5,262,499	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7,982,575	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	18,736,629	0	0	0	5,262,499	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	5,161,741	21,178,294		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,347,128	11,329,703		2.00
3.00	Total (sum of lines 1-2)	8,508,869	32,507,997		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part III Date/Time Prepared: 11/28/2018 10:46 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	205,592,946	30,640,020	174,952,926	0.793141	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	98,034,131	52,404,784	45,629,347	0.206859	0	2.00
3.00	Total (sum of lines 1-2)	303,627,077	83,044,804	220,582,273	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	12,098,482	-4,865,109	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	12,964,656	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	25,063,138	-4,865,109	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	-875,913	360,378	4,286,320	5,161,741	16,165,899	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,487,683	14,452,339	2.00
3.00	Total (sum of lines 1-2)	-875,913	360,378	4,286,320	6,649,424	30,618,238	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/28/2018 10:46 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-1,214,530	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	0			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	-107,784,182			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-1,663,660	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
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
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	-37,641	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	1,090,010	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

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/28/2018 10:46 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER REVENUE		0		0.00	0	33.00
33.01	OTHER REVENUE	B	-3,212,471	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	OTHER REVENUE		0		0.00	0	33.02
33.03	OTHER REVENUE		0		0.00	0	33.03
33.04	OTHER REVENUE	B	-1,043	MEDICAL RECORDS & LIBRARY	16.00	0	33.04
33.05	OTHER REVENUE	B	-10,414	OTHER GENERAL SERVICE (SPECIFY)	18.00	0	33.05
33.06	OTHER REVENUE	B	-28,846	INTRAVENOUS THERAPY	64.00	0	33.06
33.07	OTHER REVENUE		0		0.00	0	33.07
33.08	OTHER REVENUE		0		0.00	0	33.08
33.09	OTHER REVENUE		0		0.00	0	33.09
33.10	OTHER REVENUE		0		0.00	0	33.10
33.11	OTHER REVENUE	B	-46,060	PHYSICAL THERAPY	66.00	0	33.11
34.00	NON-ALLOWABLE EXPENSE	A	4,026	SOCIAL SERVICE	17.00	0	34.00
34.01	NON-ALLOWABLE EXPENSE		0		0.00	0	34.01
34.02	NON-ALLOWABLE EXPENSE	A	-32	ADULTS & PEDIATRICS	30.00	0	34.02
34.03	NON-ALLOWABLE EXPENSE		0		0.00	0	34.03
34.04	NON-ALLOWABLE EXPENSE		0		0.00	0	34.04
34.05	NON-ALLOWABLE EXPENSE		0		0.00	0	34.05
34.06	NON-ALLOWABLE EXPENSE		0		0.00	0	34.06
34.07	NON-ALLOWABLE EXPENSE	A	-5	MEDICAL RECORDS & LIBRARY	16.00	0	34.07
34.08	NON-ALLOWABLE EXPENSE	A	-23,687	OTHER GENERAL SERVICE (SPECIFY)	18.00	0	34.08
34.09	NON-ALLOWABLE EXPENSE	A	-291,636	DIETARY	10.00	0	34.09
34.10	NON-ALLOWABLE EXPENSE		0		0.00	0	34.10
34.11	NON-ALLOWABLE EXPENSE	A	-6,846,883	ADMINISTRATIVE & GENERAL	5.00	0	34.11
34.12	NON-ALLOWABLE EXPENSE		0		0.00	0	34.12
34.13	NON-ALLOWABLE EXPENSE		0		0.00	0	34.13
34.14	NON-ALLOWABLE EXPENSE		0		0.00	0	34.14
34.15	NON-ALLOWABLE EXPENSE	A	-39	RADIOLOGY-THERAPEUTIC	55.00	0	34.15
34.16	NON-ALLOWABLE EXPENSE		0		0.00	0	34.16
34.17	NON-ALLOWABLE EXPENSE		0		0.00	0	34.17
34.18	NON-ALLOWABLE EXPENSE		0		0.00	0	34.18
34.19	NON-ALLOWABLE EXPENSE	A	-10	HOSPITAL NUTRITION	76.01	0	34.19
34.20	NON-ALLOWABLE EXPENSE	A	-9	NURSING ADMINISTRATION	13.00	0	34.20
34.21	NON-ALLOWABLE EXPENSE		0		0.00	0	34.21
34.22	NON-ALLOWABLE EXPENSE		0		0.00	0	34.22
34.23	NON-ALLOWABLE EXPENSE		0		0.00	0	34.23
34.24	NON-ALLOWABLE EXPENSE		0		0.00	0	34.24
34.25	NON-ALLOWABLE EXPENSE	A	-12	PHARMACY	15.00	0	34.25
34.26	NON-ALLOWABLE EXPENSE		0		0.00	0	34.26
34.27	NON-ALLOWABLE EXPENSE		0		0.00	0	34.27
35.00	CAFETERIA	A	-1,040,358	CAFETERIA	11.00	0	35.00
36.00	CONSULTING FEES		0		0.00	0	36.00
37.00	EMR AMORTIZATION	A	-60,623	ADMINISTRATIVE & GENERAL	5.00	0	37.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-121,168,105				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: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-1 | Date/Time Prepared: 11/28/2018 10:46 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	0.00		MANAGEMENT FEES	0	0	1.00
2.00	0.00		RISING TIDE IP REIMBURSEMENT	0	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	TRAVEL - AIR CHARTER	103,270	2,750,000	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	GUARANTEE FEES	0	105,169	4.00
4.01	113.00	INTEREST EXPENSE	INTEREST EXPENSE - OTHER	0	95,625	4.01
4.02	2.00	CAP REL COSTS-MVBLE EQUIP	AMORT EXP - GCF CAP LEASES	4,662,065	4,662,065	4.02
4.03	2.00	CAP REL COSTS-MVBLE EQUIP	AMORT EXP - GCF CAP LEASES -	0	1,859,445	4.03
4.04	113.00	INTEREST EXPENSE	INTEREST EXPENSE - GCF	0	455,423	4.04
4.05	113.00	INTEREST EXPENSE	INTEREST EXPENSE - CAPITAL L	338,617	0	4.05
4.06	1.00	CAP REL COSTS-BLDG & FIXT	RENTAL - BLDG	259,621	5,124,730	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	SHARED SERVICES - NEW	0	42,785,670	4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	INTERCOMPANY EXPENSE	0	112,173,950	4.08
4.09	1.00	CAP REL COSTS-BLDG & FIXT	INSURANCE	360,378	406,216	4.09
4.10	4.00	EMPLOYEE BENEFITS DEPARTMENT	INSURANCE	475,977	583,633	4.10
4.11	5.00	ADMINISTRATIVE & GENERAL	INSURANCE	1,822,238	2,805,631	4.11
4.12	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOCATION	1,391,698	0	4.12
4.13	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE ALLOCATION	3,892,071	0	4.13
4.14	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	52,751,497	0	4.14
4.15	5.00	ADMINISTRATIVE & GENERAL	BROKERAGE FEES	0	34,057	4.15
5.00	0		0	66,057,432	173,841,614	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	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	A	MIDWESTERN REG	100.00	NIMP	100.00	6.00
7.00	A	MIDWESTERN REG	100.00	CTCA	100.00	7.00
8.00	A	MIDWESTERN REG	100.00	ICIC	100.00	8.00
9.00	A	MIDWESTERN REG	100.00	INTERNATIONAL A	100.00	9.00
10.00	A	MIDWESTERN REG	100.00	SCL	100.00	10.00
10.01	A	MIDWESTERN REG	100.00	EXPEDITION PROP	100.00	10.01
10.02	A	MIDWESTERN REG	100.00	BUCKLEY RD PR	100.00	10.02
10.03	A	MIDWESTERN REG	100.00	LAND TRUST	100.00	10.03
10.04	A	MIDWESTERN REG	100.00	GCF	100.00	10.04
10.05	A	MIDWESTERN REG	100.00	STELLAR INS	100.00	10.05
10.06	A	MIDWESTERN REG	100.00	ICMC	100.00	10.06
10.07			0.00		0.00	10.07
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-1 | Date/Time Prepared: 11/28/2018 10:46 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	0	0		1.00
2.00	0	0		2.00
3.00	-2,646,730	0		3.00
4.00	-105,169	0		4.00
4.01	-95,625	0		4.01
4.02	0	14		4.02
4.03	-1,859,445	14		4.03
4.04	-455,423	0		4.04
4.05	338,617	0		4.05
4.06	-4,865,109	10		4.06
4.07	-42,785,670	0		4.07
4.08	-112,173,950	0		4.08
4.09	-45,838	12		4.09
4.10	-107,656	0		4.10
4.11	-983,393	0		4.11
4.12	1,391,698	9		4.12
4.13	3,892,071	9		4.13
4.14	52,751,497	0		4.14
4.15	-34,057	0		4.15
5.00	-107,784,182			5.00

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

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

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

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

6.00	PROPERTY		6.00
7.00	MANAGEMENT		7.00
8.00	CONSULTING		8.00
9.00	CORPORATE JET		9.00
10.00	SECURITIES FINA		10.00
10.01	RENTS BLDG SHAR		10.01
10.02	PROPERTY COMP		10.02
10.03	PROPERTY COMP		10.03
10.04	FINANCIAL		10.04
10.05	INSURANCE		10.05
10.06	CAPITAL MANAGEM		10.06
10.07			10.07
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-2 | Date/Time Prepared: 11/28/2018 10:46 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	0.00		0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		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			0	0	0		0	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	0.00		0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		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			0	0	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	0.00		0	0	0	0		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		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	0	0	0		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/28/2018 10:46 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	16,165,899	16,165,899				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	14,452,339		14,452,339			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	14,871,572	104,833	3,635	14,980,040		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	61,693,817	881,442	4,261,537	1,531,642	68,368,438	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	6,514,160	2,813,784	444,545	458,771	10,231,260	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	406,837	0	0	9,515	416,352	8.00
9.00	00900	HOUSEKEEPING	2,235,348	260,566	27,684	393,537	2,917,135	9.00
10.00	01000	DIETARY	9,303	81,645	179,706	31,154	301,808	10.00
11.00	01100	CAFETERIA	637,332	952,290	4,768	349,038	1,943,428	11.00
13.00	01300	NURSING ADMINISTRATION	1,389,089	42,057	0	270,738	1,701,884	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	249,983	191,774	768,130	660	1,210,547	14.00
15.00	01500	PHARMACY	3,288,918	180,772	337,594	689,059	4,496,343	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,644,747	201,594	0	363,690	2,210,031	16.00
17.00	01700	SOCIAL SERVICE	828,253	117,584	0	133,885	1,079,722	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	2,097,970	360,515	651	450,795	2,909,931	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,018,376	2,561,600	138,249	1,075,439	8,793,664	30.00
31.00	03100	INTENSIVE CARE UNIT	4,150,176	932,753	271,644	893,072	6,247,645	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,513,226	1,373,165	1,978,173	1,212,048	11,076,612	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,496,360	568,485	1,500,158	684,264	7,249,267	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,199,521	664,834	2,073,425	451,911	8,389,691	55.00
56.00	05600	RADIOISOTOPE	498,816	20,566	144,612	97,247	761,241	56.00
57.00	05700	CT SCAN	850,737	54,602	207,414	131,048	1,243,801	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	862,407	76,401	881,846	111,318	1,931,972	58.00
60.00	06000	LABORATORY	5,860,718	428,330	317,263	588,939	7,195,250	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	947,616	15,013	172,161	0	1,134,790	63.00
64.00	06400	INTRAVENOUS THERAPY	1,939,756	490,901	105,752	431,154	2,967,563	64.00
65.00	06500	RESPIRATORY THERAPY	1,339,170	9,255	24,154	240,160	1,612,739	65.00
66.00	06600	PHYSICAL THERAPY	1,418,782	269,307	9,339	316,170	2,013,598	66.00
69.00	06900	ELECTROCARDIOLOGY	523,540	27,506	118,836	103,986	773,868	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,440,103	0	0	0	13,440,103	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	85,806,729	0	0	0	85,806,729	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	568,767	37,892	232	118,594	725,485	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	10,510,275	2,132,396	131,896	2,303,421	15,077,988	90.00
91.00	09100	EMERGENCY	977,886	118,252	46,121	193,927	1,336,186	91.00
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)	277,408,528	15,970,114	14,149,525	13,635,182	275,565,071	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-782	54,190	0	0	53,408	190.00
191.00	19100	RESEARCH	25	35,836	953	0	36,814	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	31,287,199	105,759	301,861	1,344,858	33,039,677	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	308,694,970	16,165,899	14,452,339	14,980,040	308,694,970	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/28/2018 10:46 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	68,368,438					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	2,910,599	0	13,141,859			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	118,444	0	0	534,796		8.00
9.00	00900	HOUSEKEEPING	829,869	0	276,734	0	4,023,738	9.00
10.00	01000	DIETARY	85,859	0	86,711	0	27,139	10.00
11.00	01100	CAFETERIA	552,868	0	1,011,378	0	316,537	11.00
13.00	01300	NURSING ADMINISTRATION	484,154	0	44,666	0	13,979	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	344,378	0	203,674	0	63,745	14.00
15.00	01500	PHARMACY	1,279,124	0	191,988	0	60,088	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	628,712	0	214,103	0	67,009	16.00
17.00	01700	SOCIAL SERVICE	307,160	0	124,880	0	39,084	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	827,820	0	382,884	1,855	119,834	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,501,630	0	2,720,544	86,013	851,464	30.00
31.00	03100	INTENSIVE CARE UNIT	1,777,336	0	990,629	95,385	310,043	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,151,086	0	1,458,368	79,877	456,434	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,062,279	0	603,758	119,541	188,962	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,386,708	0	706,087	59,297	220,988	55.00
56.00	05600	RADIOISOTOPE	216,559	0	21,842	0	6,836	56.00
57.00	05700	CT SCAN	353,838	0	57,990	0	18,149	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	549,609	0	81,142	0	25,395	58.00
60.00	06000	LABORATORY	2,046,912	0	454,907	0	142,375	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	322,826	0	15,944	0	4,990	63.00
64.00	06400	INTRAVENOUS THERAPY	844,215	0	521,361	44,991	163,173	64.00
65.00	06500	RESPIRATORY THERAPY	458,794	0	9,829	0	3,076	65.00
66.00	06600	PHYSICAL THERAPY	572,830	0	286,017	13,342	89,516	66.00
69.00	06900	ELECTROCARDIOLOGY	220,151	0	29,213	5,760	9,143	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,823,454	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	24,410,489	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	206,387	0	40,243	0	12,595	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,289,401	0	2,264,708	20,944	708,799	90.00
91.00	09100	EMERGENCY	380,120	0	125,590	6,711	39,306	91.00
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)	58,943,611	0	12,925,190	533,716	3,958,659	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,194	0	57,553	0	18,013	190.00
191.00	19100	RESEARCH	10,473	0	38,059	0	11,912	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	9,399,160	0	121,057	1,080	35,154	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	68,368,438	0	13,141,859	534,796	4,023,738	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/28/2018 10:46 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	501,517					10.00
11.00	01100	CAFETERIA	0	3,824,211				11.00
13.00	01300	NURSING ADMINISTRATION	0	61,861	2,306,544			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,230	0	1,824,574		14.00
15.00	01500	PHARMACY	0	191,133	0	0	6,218,676	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	123,877	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	52,646	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	127,508	0	0	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	418,226	316,194	613,063	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	272,596	568,555	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	348,041	725,911	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	196,991	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	136,838	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	20,317	0	0	0	56.00
57.00	05700	CT SCAN	0	34,790	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	27,294	0	0	0	58.00
60.00	06000	LABORATORY	0	206,955	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	81,559	114,352	238,505	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	69,453	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	96,027	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	26,876	56,055	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,824,574	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	6,218,676	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	0	39,841	0	0	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	713,836	0	0	0	90.00
91.00	09100	EMERGENCY	1,732	50,082	104,455	0	0	91.00
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)	501,517	3,229,738	2,306,544	1,824,574	6,218,676	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	594,473	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	501,517	3,824,211	2,306,544	1,824,574	6,218,676	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/28/2018 10:46 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	18.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,243,732					16.00
17.00	01700	SOCIAL SERVICE	0	1,603,492				17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	4,369,832			18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	49,739	24,595	67,017	16,442,149	0	30.00
31.00	03100	INTENSIVE CARE UNIT	39,088	19,328	52,666	10,373,271	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	259,687	128,409	349,896	18,034,321	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	131,809	65,176	177,596	10,795,379	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	195,661	96,749	263,629	12,455,648	0	55.00
56.00	05600	RADIOISOTOPE	13,644	6,747	18,384	1,065,570	0	56.00
57.00	05700	CT SCAN	236,165	116,778	318,203	2,379,714	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58,894	29,121	79,352	2,782,779	0	58.00
60.00	06000	LABORATORY	203,255	100,505	273,861	10,624,020	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	20,306	10,041	27,360	1,536,257	0	63.00
64.00	06400	INTRAVENOUS THERAPY	78,768	38,949	106,130	5,199,566	0	64.00
65.00	06500	RESPIRATORY THERAPY	11,443	5,658	15,418	2,186,410	0	65.00
66.00	06600	PHYSICAL THERAPY	9,937	4,913	13,388	3,099,568	0	66.00
69.00	06900	ELECTROCARDIOLOGY	19,085	9,437	25,714	1,175,302	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	88,611	43,816	119,392	19,339,950	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	1,782,991	881,192	2,401,666	121,501,743	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	4,086	2,021	5,506	1,036,164	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	32,597	16,118	43,920	23,168,311	0	90.00
91.00	09100	EMERGENCY	7,966	3,939	10,734	2,066,821	0	91.00
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)	3,243,732	1,603,492	4,369,832	265,262,943	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	144,168	0	190.00
191.00	19100	RESEARCH	0	0	0	97,258	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	43,190,601	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,243,732	1,603,492	4,369,832	308,694,970	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/28/2018 10:46 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)			18.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	16,442,149		30.00
31.00	03100	INTENSIVE CARE UNIT	10,373,271		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		34.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	18,034,321		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,795,379		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	12,455,648		55.00
56.00	05600	RADIOISOTOPE	1,065,570		56.00
57.00	05700	CT SCAN	2,379,714		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,782,779		58.00
60.00	06000	LABORATORY	10,624,020		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,536,257		63.00
64.00	06400	INTRAVENOUS THERAPY	5,199,566		64.00
65.00	06500	RESPIRATORY THERAPY	2,186,410		65.00
66.00	06600	PHYSICAL THERAPY	3,099,568		66.00
69.00	06900	ELECTROCARDIOLOGY	1,175,302		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,339,950		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	121,501,743		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		76.00
76.01	03951	HOSPITAL NUTRITION	1,036,164		76.01
76.02	03952	PAIN MANAGEMENT	0		76.02
76.03	03954	INFUSION CENTER	0		76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	23,168,311		90.00
91.00	09100	EMERGENCY	2,066,821		91.00
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)	265,262,943		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	144,168		190.00
191.00	19100	RESEARCH	97,258		191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	43,190,601		194.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	308,694,970		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/28/2018 10:46 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		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	104,833	3,635	108,468	108,468	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	881,442	4,261,537	5,142,979	11,089	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	2,813,784	444,545	3,258,329	3,321	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	69	8.00
9.00	00900	HOUSEKEEPING	0	260,566	27,684	288,250	2,849	9.00
10.00	01000	DIETARY	0	81,645	179,706	261,351	226	10.00
11.00	01100	CAFETERIA	0	952,290	4,768	957,058	2,527	11.00
13.00	01300	NURSING ADMINISTRATION	0	42,057	0	42,057	1,960	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	191,774	768,130	959,904	5	14.00
15.00	01500	PHARMACY	0	180,772	337,594	518,366	4,989	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	201,594	0	201,594	2,633	16.00
17.00	01700	SOCIAL SERVICE	0	117,584	0	117,584	969	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	360,515	651	361,166	3,264	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,561,600	138,249	2,699,849	7,786	30.00
31.00	03100	INTENSIVE CARE UNIT	0	932,753	271,644	1,204,397	6,466	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,373,165	1,978,173	3,351,338	8,775	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	568,485	1,500,158	2,068,643	4,954	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	664,834	2,073,425	2,738,259	3,272	55.00
56.00	05600	RADIOISOTOPE	0	20,566	144,612	165,178	704	56.00
57.00	05700	CT SCAN	0	54,602	207,414	262,016	949	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	76,401	881,846	958,247	806	58.00
60.00	06000	LABORATORY	0	428,330	317,263	745,593	4,264	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	15,013	172,161	187,174	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	490,901	105,752	596,653	3,122	64.00
65.00	06500	RESPIRATORY THERAPY	0	9,255	24,154	33,409	1,739	65.00
66.00	06600	PHYSICAL THERAPY	0	269,307	9,339	278,646	2,289	66.00
69.00	06900	ELECTROCARDIOLOGY	0	27,506	118,836	146,342	753	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	0	37,892	232	38,124	859	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,132,396	131,896	2,264,292	16,688	90.00
91.00	09100	EMERGENCY	0	118,252	46,121	164,373	1,404	91.00
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	15,970,114	14,149,525	30,119,639	98,731	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	54,190	0	54,190	0	190.00
191.00	19100	RESEARCH	0	35,836	953	36,789	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	105,759	301,861	407,620	9,737	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	16,165,899	14,452,339	30,618,238	108,468	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/28/2018 10:46 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,154,068					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	219,420	0	3,481,070			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,929	0	0	8,998		8.00
9.00	00900	HOUSEKEEPING	62,561	0	73,302	0	426,962	9.00
10.00	01000	DIETARY	6,473	0	22,968	0	2,880	10.00
11.00	01100	CAFETERIA	41,679	0	267,898	0	33,588	11.00
13.00	01300	NURSING ADMINISTRATION	36,499	0	11,831	0	1,483	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	25,961	0	53,950	0	6,764	14.00
15.00	01500	PHARMACY	96,429	0	50,855	0	6,376	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	47,396	0	56,712	0	7,110	16.00
17.00	01700	SOCIAL SERVICE	23,156	0	33,079	0	4,147	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	62,406	0	101,420	31	12,716	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	188,589	0	720,630	1,447	90,350	30.00
31.00	03100	INTENSIVE CARE UNIT	133,987	0	262,402	1,605	32,899	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	237,549	0	386,299	1,344	48,433	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	155,468	0	159,926	2,012	20,051	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	179,925	0	187,031	998	23,449	55.00
56.00	05600	RADIOISOTOPE	16,326	0	5,786	0	725	56.00
57.00	05700	CT SCAN	26,675	0	15,361	0	1,926	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	41,433	0	21,493	0	2,695	58.00
60.00	06000	LABORATORY	154,309	0	120,498	0	15,108	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	24,337	0	4,223	0	530	63.00
64.00	06400	INTRAVENOUS THERAPY	63,642	0	138,100	757	17,314	64.00
65.00	06500	RESPIRATORY THERAPY	34,587	0	2,603	0	326	65.00
66.00	06600	PHYSICAL THERAPY	43,184	0	75,761	224	9,499	66.00
69.00	06900	ELECTROCARDIOLOGY	16,596	0	7,738	97	970	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	288,236	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	1,840,234	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	15,559	0	10,660	0	1,336	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	323,363	0	599,885	352	75,211	90.00
91.00	09100	EMERGENCY	28,656	0	33,267	113	4,171	91.00
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)	4,443,564	0	3,423,678	8,980	420,057	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,145	0	15,245	0	1,911	190.00
191.00	19100	RESEARCH	790	0	10,081	0	1,264	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	708,569	0	32,066	18	3,730	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,154,068	0	3,481,070	8,998	426,962	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/28/2018 10:46 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	293,898					10.00
11.00	01100	CAFETERIA	0	1,302,750				11.00
13.00	01300	NURSING ADMINISTRATION	0	21,073	114,903			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	760	0	1,047,344		14.00
15.00	01500	PHARMACY	0	65,111	0	0	742,126	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	42,200	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	17,934	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	43,437	0	0	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	245,088	107,714	30,540	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	92,862	28,323	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	118,563	36,163	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	67,106	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	46,615	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	6,921	0	0	0	56.00
57.00	05700	CT SCAN	0	11,851	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	9,298	0	0	0	58.00
60.00	06000	LABORATORY	0	70,501	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	47,795	38,955	11,881	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	23,660	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	32,712	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	9,156	2,792	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,047,344	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	742,126	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	0	13,572	0	0	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	243,176	0	0	0	90.00
91.00	09100	EMERGENCY	1,015	17,061	5,204	0	0	91.00
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)	293,898	1,100,238	114,903	1,047,344	742,126	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	202,512	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	293,898	1,302,750	114,903	1,047,344	742,126	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/28/2018 10:46 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	18.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	357,645					16.00
17.00	01700	SOCIAL SERVICE	0	196,869				17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	584,440			18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,479	3,023	8,965	4,109,460	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,306	2,375	7,046	1,776,668	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	28,605	15,782	46,808	4,279,659	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,519	8,010	23,758	2,524,447	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	21,552	11,891	35,268	3,248,260	0	55.00
56.00	05600	RADIOISOTOPE	1,503	829	2,459	200,431	0	56.00
57.00	05700	CT SCAN	26,014	14,353	42,568	401,713	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,487	3,579	10,615	1,054,653	0	58.00
60.00	06000	LABORATORY	22,389	12,353	36,637	1,181,652	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,237	1,234	3,660	223,395	0	63.00
64.00	06400	INTRAVENOUS THERAPY	8,676	4,787	14,198	945,880	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,260	695	2,063	100,342	0	65.00
66.00	06600	PHYSICAL THERAPY	1,095	604	1,791	445,805	0	66.00
69.00	06900	ELECTROCARDIOLOGY	2,102	1,160	3,440	191,146	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,761	5,385	15,972	1,366,698	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	196,741	108,096	321,143	3,208,340	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	450	248	737	81,545	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,591	1,981	5,876	3,534,415	0	90.00
91.00	09100	EMERGENCY	878	484	1,436	258,062	0	91.00
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)	357,645	196,869	584,440	29,132,571	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	72,491	0	190.00
191.00	19100	RESEARCH	0	0	0	48,924	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	1,364,252	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	357,645	196,869	584,440	30,618,238	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/28/2018 10:46 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)			18.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	4,109,460		30.00
31.00	03100	INTENSIVE CARE UNIT	1,776,668		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		34.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	4,279,659		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,524,447		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,248,260		55.00
56.00	05600	RADIOISOTOPE	200,431		56.00
57.00	05700	CT SCAN	401,713		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,054,653		58.00
60.00	06000	LABORATORY	1,181,652		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	223,395		63.00
64.00	06400	INTRAVENOUS THERAPY	945,880		64.00
65.00	06500	RESPIRATORY THERAPY	100,342		65.00
66.00	06600	PHYSICAL THERAPY	445,805		66.00
69.00	06900	ELECTROCARDIOLOGY	191,146		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,366,698		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,208,340		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		76.00
76.01	03951	HOSPITAL NUTRITION	81,545		76.01
76.02	03952	PAIN MANAGEMENT	0		76.02
76.03	03954	INFUSION CENTER	0		76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	3,534,415		90.00
91.00	09100	EMERGENCY	258,062		91.00
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)	29,132,571		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	72,491		190.00
191.00	19100	RESEARCH	48,924		191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	1,364,252		194.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	30,618,238		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/28/2018 10:46 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	314,426					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		14,452,340				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,039	3,635	60,051,920			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,144	4,261,538	6,140,053	-68,368,438	240,326,532	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	54,728	444,545	1,839,122	0	10,231,260	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	38,145	0	416,352	8.00
9.00	00900	HOUSEKEEPING	5,068	27,684	1,577,612	0	2,917,135	9.00
10.00	01000	DIETARY	1,588	179,706	124,889	0	301,808	10.00
11.00	01100	CAFETERIA	18,522	4,768	1,399,226	0	1,943,428	11.00
13.00	01300	NURSING ADMINISTRATION	818	0	1,085,335	0	1,701,884	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,730	768,130	2,646	0	1,210,547	14.00
15.00	01500	PHARMACY	3,516	337,594	2,762,301	0	4,496,343	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,921	0	1,457,962	0	2,210,031	16.00
17.00	01700	SOCIAL SERVICE	2,287	0	536,720	0	1,079,722	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	7,012	651	1,807,150	0	2,909,931	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	49,823	138,249	4,311,225	0	8,793,664	30.00
31.00	03100	INTENSIVE CARE UNIT	18,142	271,644	3,580,150	0	6,247,645	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,708	1,978,173	4,858,864	0	11,076,612	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,057	1,500,158	2,743,079	0	7,249,267	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	12,931	2,073,425	1,811,624	0	8,389,691	55.00
56.00	05600	RADIOISOTOPE	400	144,612	389,843	0	761,241	56.00
57.00	05700	CT SCAN	1,062	207,414	525,344	0	1,243,801	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,486	881,846	446,253	0	1,931,972	58.00
60.00	06000	LABORATORY	8,331	317,263	2,360,941	0	7,195,250	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	292	172,161	0	0	1,134,790	63.00
64.00	06400	INTRAVENOUS THERAPY	9,548	105,752	1,728,412	0	2,967,563	64.00
65.00	06500	RESPIRATORY THERAPY	180	24,154	962,755	0	1,612,739	65.00
66.00	06600	PHYSICAL THERAPY	5,238	9,339	1,267,464	0	2,013,598	66.00
69.00	06900	ELECTROCARDIOLOGY	535	118,836	416,860	0	773,868	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	13,440,103	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	85,806,729	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	737	232	475,421	0	725,485	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	41,475	131,896	9,233,836	0	15,077,988	90.00
91.00	09100	EMERGENCY	2,300	46,121	777,417	0	1,336,186	91.00
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)	310,618	14,149,526	54,660,649	-68,368,438	207,196,633	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,054	0	0	0	53,408	190.00
191.00	19100	RESEARCH	697	953	0	0	36,814	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	2,057	301,861	5,391,271	0	33,039,677	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	16,165,899	14,452,339	14,980,040		68,368,438	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	51.414002	1.000000	0.249451		0.284481	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			108,468		5,154,068	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001806		0.021446	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: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/28/2018 10:46 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	295,243					6.00
7.00	00700	OPERATION OF PLANT	54,728	240,675				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	435,244			8.00
9.00	00900	HOUSEKEEPING	5,068	5,068	0	235,447		9.00
10.00	01000	DIETARY	1,588	1,588	0	1,588	26,349	10.00
11.00	01100	CAFETERIA	18,522	18,522	0	18,522	0	11.00
13.00	01300	NURSING ADMINISTRATION	818	818	0	818	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,730	3,730	0	3,730	0	14.00
15.00	01500	PHARMACY	3,516	3,516	0	3,516	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,921	3,921	0	3,921	0	16.00
17.00	01700	SOCIAL SERVICE	2,287	2,287	0	2,287	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	7,012	7,012	1,510	7,012	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	49,823	49,823	70,002	49,823	21,973	30.00
31.00	03100	INTENSIVE CARE UNIT	18,142	18,142	77,629	18,142	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,708	26,708	65,008	26,708	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,057	11,057	97,288	11,057	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	12,931	12,931	48,259	12,931	0	55.00
56.00	05600	RADIOISOTOPE	400	400	0	400	0	56.00
57.00	05700	CT SCAN	1,062	1,062	0	1,062	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,486	1,486	0	1,486	0	58.00
60.00	06000	LABORATORY	8,331	8,331	0	8,331	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	292	292	0	292	0	63.00
64.00	06400	INTRAVENOUS THERAPY	9,548	9,548	36,616	9,548	4,285	64.00
65.00	06500	RESPIRATORY THERAPY	180	180	0	180	0	65.00
66.00	06600	PHYSICAL THERAPY	5,238	5,238	10,858	5,238	0	66.00
69.00	06900	ELECTROCARDIOLOGY	535	535	4,688	535	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	737	737	0	737	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	41,475	41,475	17,045	41,475	0	90.00
91.00	09100	EMERGENCY	2,300	2,300	5,462	2,300	91	91.00
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)	291,435	236,707	434,365	231,639	26,349	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,054	1,054	0	1,054	0	190.00
191.00	19100	RESEARCH	697	697	0	697	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	2,057	2,217	879	2,057	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	13,141,859	534,796	4,023,738	501,517	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	54.604172	1.228727	17.089782	19.033626	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	3,481,070	8,998	426,962	293,898	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	14.463779	0.020673	1.813410	11.154048	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: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/28/2018 10:46 am

		Cost Center Description	CAFETERIA (ASSIGNED TIME)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,428,460					11.00
13.00	01300	NURSING ADMINISTRATION	23,107	413,081				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	833	0	1,000			14.00
15.00	01500	PHARMACY	71,394	0	0	1,000		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	46,272	0	0	0	1,119,898,895	16.00
17.00	01700	SOCIAL SERVICE	19,665	0	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	47,628	0	0	0	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	118,108	109,794	0	0	17,175,083	30.00
31.00	03100	INTENSIVE CARE UNIT	101,823	101,823	0	0	13,497,143	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	130,004	130,004	0	0	89,670,985	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	73,582	0	0	0	45,514,097	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	51,113	0	0	0	67,562,406	55.00
56.00	05600	RADIOISOTOPE	7,589	0	0	0	4,711,329	56.00
57.00	05700	CT SCAN	12,995	0	0	0	81,548,701	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	10,195	0	0	0	20,336,176	58.00
60.00	06000	LABORATORY	77,304	0	0	0	70,184,889	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	7,011,817	63.00
64.00	06400	INTRAVENOUS THERAPY	42,714	42,714	0	0	27,198,838	64.00
65.00	06500	RESPIRATORY THERAPY	25,943	0	0	0	3,951,360	65.00
66.00	06600	PHYSICAL THERAPY	35,869	0	0	0	3,431,159	66.00
69.00	06900	ELECTROCARDIOLOGY	10,039	10,039	0	0	6,590,041	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,000	0	30,597,769	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	1,000	615,499,435	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	14,882	0	0	0	1,411,040	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	266,640	0	0	0	11,255,771	90.00
91.00	09100	EMERGENCY	18,707	18,707	0	0	2,750,856	91.00
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)	1,206,406	413,081	1,000	1,000	1,119,898,895	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	222,054	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,824,211	2,306,544	1,824,574	6,218,676	3,243,732	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.677157	5.583757	1,824.574000	6,218.676000	0.002896	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,302,750	114,903	1,047,344	742,126	357,645	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.911996	0.278161	1,047.344000	742.126000	0.000319	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: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/28/2018 10:46 am

		Cost Center Description	SOCIAL SERVICE (GROSS CHARGES)	OTHER GENERAL SERVICE (SPECIFY) (GROSS CHARGES)		
			17.00	18.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	1,119,898,895			17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	1,119,898,895		18.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	17,175,083	17,175,083		30.00
31.00	03100	INTENSIVE CARE UNIT	13,497,143	13,497,143		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0		34.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	89,670,985	89,670,985		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	45,514,097	45,514,097		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	67,562,406	67,562,406		55.00
56.00	05600	RADIOISOTOPE	4,711,329	4,711,329		56.00
57.00	05700	CT SCAN	81,548,701	81,548,701		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	20,336,176	20,336,176		58.00
60.00	06000	LABORATORY	70,184,889	70,184,889		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	7,011,817	7,011,817		63.00
64.00	06400	INTRAVENOUS THERAPY	27,198,838	27,198,838		64.00
65.00	06500	RESPIRATORY THERAPY	3,951,360	3,951,360		65.00
66.00	06600	PHYSICAL THERAPY	3,431,159	3,431,159		66.00
69.00	06900	ELECTROCARDIOLOGY	6,590,041	6,590,041		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	30,597,769	30,597,769		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	615,499,435	615,499,435		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.01	03951	HOSPITAL NUTRITION	1,411,040	1,411,040		76.01
76.02	03952	PAIN MANAGEMENT	0	0		76.02
76.03	03954	INFUSION CENTER	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	11,255,771	11,255,771		90.00
91.00	09100	EMERGENCY	2,750,856	2,750,856		91.00
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)	1,119,898,895	1,119,898,895		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.00
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,603,492	4,369,832		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.001432	0.003902		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	196,869	584,440		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000176	0.000522		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: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/28/2018 10:46 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,442,149		16,442,149	0	16,442,149	30.00
31.00	03100	INTENSIVE CARE UNIT	10,373,271		10,373,271	0	10,373,271	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,034,321		18,034,321	0	18,034,321	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,795,379		10,795,379	0	10,795,379	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	12,455,648		12,455,648	0	12,455,648	55.00
56.00	05600	RADIOISOTOPE	1,065,570		1,065,570	0	1,065,570	56.00
57.00	05700	CT SCAN	2,379,714		2,379,714	0	2,379,714	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,782,779		2,782,779	0	2,782,779	58.00
60.00	06000	LABORATORY	10,624,020		10,624,020	0	10,624,020	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,536,257		1,536,257	0	1,536,257	63.00
64.00	06400	INTRAVENOUS THERAPY	5,199,566		5,199,566	0	5,199,566	64.00
65.00	06500	RESPIRATORY THERAPY	2,186,410	0	2,186,410	0	2,186,410	65.00
66.00	06600	PHYSICAL THERAPY	3,099,568	0	3,099,568	0	3,099,568	66.00
69.00	06900	ELECTROCARDIOLOGY	1,175,302		1,175,302	0	1,175,302	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,339,950		19,339,950	0	19,339,950	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	121,501,743		121,501,743	0	121,501,743	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	1,036,164		1,036,164	0	1,036,164	76.01
76.02	03952	PAIN MANAGEMENT	0		0	0	0	76.02
76.03	03954	INFUSION CENTER	0		0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	23,168,311		23,168,311	0	23,168,311	90.00
91.00	09100	EMERGENCY	2,066,821		2,066,821	0	2,066,821	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,971,834		2,971,834		2,971,834	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	268,234,777	0	268,234,777	0	268,234,777	200.00
201.00		Less Observation Beds	2,971,834		2,971,834		2,971,834	201.00
202.00		Total (see instructions)	265,262,943	0	265,262,943	0	265,262,943	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/28/2018 10:46 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,929,922		14,929,922			30.00
31.00	03100	INTENSIVE CARE UNIT	13,497,143		13,497,143			31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0			34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	42,570,360	47,100,625	89,670,985	0.201117	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,626,309	39,887,788	45,514,097	0.237188	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,206,007	65,356,399	67,562,406	0.184358	0.000000	55.00
56.00	05600	RADIOISOTOPE	109,984	4,601,345	4,711,329	0.226172	0.000000	56.00
57.00	05700	CT SCAN	4,201,676	77,347,025	81,548,701	0.029182	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,780,540	18,555,636	20,336,176	0.136839	0.000000	58.00
60.00	06000	LABORATORY	13,363,233	56,821,656	70,184,889	0.151372	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	4,044,015	2,967,802	7,011,817	0.219095	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	95,017	27,103,821	27,198,838	0.191169	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,051,916	2,899,444	3,951,360	0.553331	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,642,984	1,788,175	3,431,159	0.903359	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	1,306,803	5,283,238	6,590,041	0.178345	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,955,688	13,642,081	30,597,769	0.632071	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	61,232,025	554,267,410	615,499,435	0.197404	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
76.01	03951	HOSPITAL NUTRITION	158,521	1,252,519	1,411,040	0.734326	0.000000	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0.000000	0.000000	76.02
76.03	03954	INFUSION CENTER	0	0	0	0.000000	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	140,490	11,115,281	11,255,771	2.058350	0.000000	90.00
91.00	09100	EMERGENCY	976,986	1,773,870	2,750,856	0.751337	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	783,200	1,461,961	2,245,161	1.323662	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	186,672,819	933,226,076	1,119,898,895			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	186,672,819	933,226,076	1,119,898,895			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/28/2018 10:46 am

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
34.00	03400	SURGICAL INTENSIVE CARE UNIT		34.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.201117	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.237188	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.184358	55.00
56.00	05600	RADIOISOTOPE	0.226172	56.00
57.00	05700	CT SCAN	0.029182	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.136839	58.00
60.00	06000	LABORATORY	0.151372	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.219095	63.00
64.00	06400	INTRAVENOUS THERAPY	0.191169	64.00
65.00	06500	RESPIRATORY THERAPY	0.553331	65.00
66.00	06600	PHYSICAL THERAPY	0.903359	66.00
69.00	06900	ELECTROCARDIOLOGY	0.178345	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.632071	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.197404	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	76.00
76.01	03951	HOSPITAL NUTRITION	0.734326	76.01
76.02	03952	PAIN MANAGEMENT	0.000000	76.02
76.03	03954	INFUSION CENTER	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	2.058350	90.00
91.00	09100	EMERGENCY	0.751337	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.323662	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: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/28/2018 10:46 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,442,149		16,442,149	0	16,442,149	30.00
31.00	03100	INTENSIVE CARE UNIT	10,373,271		10,373,271	0	10,373,271	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,034,321		18,034,321	0	18,034,321	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,795,379		10,795,379	0	10,795,379	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	12,455,648		12,455,648	0	12,455,648	55.00
56.00	05600	RADIOISOTOPE	1,065,570		1,065,570	0	1,065,570	56.00
57.00	05700	CT SCAN	2,379,714		2,379,714	0	2,379,714	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,782,779		2,782,779	0	2,782,779	58.00
60.00	06000	LABORATORY	10,624,020		10,624,020	0	10,624,020	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,536,257		1,536,257	0	1,536,257	63.00
64.00	06400	INTRAVENOUS THERAPY	5,199,566		5,199,566	0	5,199,566	64.00
65.00	06500	RESPIRATORY THERAPY	2,186,410	0	2,186,410	0	2,186,410	65.00
66.00	06600	PHYSICAL THERAPY	3,099,568	0	3,099,568	0	3,099,568	66.00
69.00	06900	ELECTROCARDIOLOGY	1,175,302		1,175,302	0	1,175,302	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,339,950		19,339,950	0	19,339,950	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	121,501,743		121,501,743	0	121,501,743	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	1,036,164		1,036,164	0	1,036,164	76.01
76.02	03952	PAIN MANAGEMENT	0		0	0	0	76.02
76.03	03954	INFUSION CENTER	0		0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	23,168,311		23,168,311	0	23,168,311	90.00
91.00	09100	EMERGENCY	2,066,821		2,066,821	0	2,066,821	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,971,834		2,971,834		2,971,834	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	268,234,777	0	268,234,777	0	268,234,777	200.00
201.00		Less Observation Beds	2,971,834		2,971,834		2,971,834	201.00
202.00		Total (see instructions)	265,262,943	0	265,262,943	0	265,262,943	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/28/2018 10:46 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,929,922		14,929,922			30.00
31.00	03100	INTENSIVE CARE UNIT	13,497,143		13,497,143			31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0			34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	42,570,360	47,100,625	89,670,985	0.201117	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,626,309	39,887,788	45,514,097	0.237188	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,206,007	65,356,399	67,562,406	0.184358	0.000000	55.00
56.00	05600	RADIOISOTOPE	109,984	4,601,345	4,711,329	0.226172	0.000000	56.00
57.00	05700	CT SCAN	4,201,676	77,347,025	81,548,701	0.029182	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,780,540	18,555,636	20,336,176	0.136839	0.000000	58.00
60.00	06000	LABORATORY	13,363,233	56,821,656	70,184,889	0.151372	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	4,044,015	2,967,802	7,011,817	0.219095	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	95,017	27,103,821	27,198,838	0.191169	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,051,916	2,899,444	3,951,360	0.553331	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,642,984	1,788,175	3,431,159	0.903359	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	1,306,803	5,283,238	6,590,041	0.178345	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,955,688	13,642,081	30,597,769	0.632071	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	61,232,025	554,267,410	615,499,435	0.197404	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
76.01	03951	HOSPITAL NUTRITION	158,521	1,252,519	1,411,040	0.734326	0.000000	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0.000000	0.000000	76.02
76.03	03954	INFUSION CENTER	0	0	0	0.000000	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	140,490	11,115,281	11,255,771	2.058350	0.000000	90.00
91.00	09100	EMERGENCY	976,986	1,773,870	2,750,856	0.751337	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	783,200	1,461,961	2,245,161	1.323662	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	186,672,819	933,226,076	1,119,898,895			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	186,672,819	933,226,076	1,119,898,895			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/28/2018 10:46 am

Title XIX | Hospital | Cost

		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
34.00	03400	SURGICAL INTENSIVE CARE UNIT			34.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.00
76.01	03951	HOSPITAL NUTRITION	0.000000		76.01
76.02	03952	PAIN MANAGEMENT	0.000000		76.02
76.03	03954	INFUSION CENTER	0.000000		76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part I Date/Time Prepared: 11/28/2018 10:46 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	4,109,460	0	4,109,460	4,913	836.45	30.00
31.00	INTENSIVE CARE UNIT	1,776,668		1,776,668	4,540	391.34	31.00
34.00	SURGICAL INTENSIVE CARE UNIT	0		0	0	0.00	34.00
200.00	Total (lines 30 through 199)	5,886,128		5,886,128	9,453		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	1,247	1,043,053		30.00
31.00	INTENSIVE CARE UNIT	330	129,142		31.00
34.00	SURGICAL INTENSIVE CARE UNIT	0	0		34.00
200.00	Total (lines 30 through 199)	1,577	1,172,195		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part II Date/Time Prepared: 11/28/2018 10:46 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,279,659	89,670,985	0.047726	6,639,318	316,868	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,524,447	45,514,097	0.055465	1,064,770	59,057	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,248,260	67,562,406	0.048078	403,820	19,415	55.00
56.00	05600	RADIOISOTOPE	200,431	4,711,329	0.042542	32,023	1,362	56.00
57.00	05700	CT SCAN	401,713	81,548,701	0.004926	995,437	4,904	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,054,653	20,336,176	0.051861	370,591	19,219	58.00
60.00	06000	LABORATORY	1,181,652	70,184,889	0.016836	2,734,955	46,046	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	223,395	7,011,817	0.031860	656,103	20,903	63.00
64.00	06400	INTRAVENOUS THERAPY	945,880	27,198,838	0.034776	3,507	122	64.00
65.00	06500	RESPIRATORY THERAPY	100,342	3,951,360	0.025394	268,994	6,831	65.00
66.00	06600	PHYSICAL THERAPY	445,805	3,431,159	0.129928	344,237	44,726	66.00
69.00	06900	ELECTROCARDIOLOGY	191,146	6,590,041	0.029005	360,610	10,459	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,366,698	30,597,769	0.044667	2,914,134	130,166	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,208,340	615,499,435	0.005213	9,345,910	48,720	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	81,545	1,411,040	0.057791	33,918	1,960	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0.000000	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0.000000	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,534,415	11,255,771	0.314009	15,010	4,713	90.00
91.00	09100	EMERGENCY	258,062	2,750,856	0.093812	261,386	24,521	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	742,762	2,245,161	0.330828	147,690	48,860	92.00
200.00		Total (lines 50 through 199)	23,989,205	1,091,471,830		26,592,413	808,852	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part III Date/Time Prepared: 11/28/2018 10:46 am

Title XVIII | Hospital | PPS

		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
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
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	4,913	0.00	1,247	30.00
31.00	03100	INTENSIVE CARE UNIT		0	4,540	0.00	330	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	0	0.00	0	34.00
200.00		Total (lines 30 through 199)		0	9,453		1,577	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
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	34.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/28/2018 10:46 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
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 PATIENTS	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
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	0	0	0	0	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	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: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/28/2018 10:46 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	89,670,985	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	45,514,097	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	67,562,406	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	4,711,329	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	81,548,701	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	20,336,176	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	70,184,889	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	7,011,817	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	27,198,838	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,951,360	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,431,159	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	6,590,041	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	30,597,769	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	615,499,435	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.00
76.01	03951	HOSPITAL NUTRITION	0	0	0	1,411,040	0.000000	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0.000000	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	11,255,771	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	2,750,856	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,245,161	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	1,091,471,830		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/28/2018 10:46 am

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	6,639,318	0	7,639,541	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,064,770	0	6,998,902	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	403,820	0	14,135,832	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	32,023	0	828,099	0	56.00
57.00	05700	CT SCAN	0.000000	995,437	0	14,658,456	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	370,591	0	3,066,306	0	58.00
60.00	06000	LABORATORY	0.000000	2,734,955	0	9,294,127	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	656,103	0	627,472	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	3,507	0	4,928,845	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	268,994	0	502,727	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	344,237	0	39,769	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	360,610	0	1,018,791	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	2,914,134	0	1,574,421	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	9,345,910	0	97,832,813	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	0.000000	33,918	0	0	0	76.01
76.02	03952	PAIN MANAGEMENT	0.000000	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	15,010	0	1,731,629	0	90.00
91.00	09100	EMERGENCY	0.000000	261,386	0	344,089	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	147,690	0	257,394	0	92.00
200.00		Total (lines 50 through 199)		26,592,413	0	165,479,213	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/28/2018 10:46 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.201117	7,639,541	0	0	1,536,442	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.237188	6,998,902	0	0	1,660,056	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.184358	14,135,832	0	0	2,606,054	55.00
56.00	05600	RADIOISOTOPE	0.226172	828,099	0	0	187,293	56.00
57.00	05700	CT SCAN	0.029182	14,658,456	0	0	427,763	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.136839	3,066,306	0	0	419,590	58.00
60.00	06000	LABORATORY	0.151372	9,294,127	0	0	1,406,871	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.219095	627,472	0	0	137,476	63.00
64.00	06400	INTRAVENOUS THERAPY	0.191169	4,928,845	0	0	942,242	64.00
65.00	06500	RESPIRATORY THERAPY	0.553331	502,727	0	0	278,174	65.00
66.00	06600	PHYSICAL THERAPY	0.903359	39,769	0	0	35,926	66.00
69.00	06900	ELECTROCARDIOLOGY	0.178345	1,018,791	0	0	181,696	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.632071	1,574,421	0	0	995,146	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.197404	97,832,813	0	210,404	19,312,589	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	0.734326	0	0	0	0	76.01
76.02	03952	PAIN MANAGEMENT	0.000000	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2.058350	1,731,629	0	1,540	3,564,299	90.00
91.00	09100	EMERGENCY	0.751337	344,089	0	0	258,527	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.323662	257,394	0	0	340,703	92.00
200.00		Subtotal (see instructions)		165,479,213	0	211,944	34,290,847	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		165,479,213	0	211,944	34,290,847	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/28/2018 10:46 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
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 PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	41,535		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.01	03951	HOSPITAL NUTRITION	0	0		76.01
76.02	03952	PAIN MANAGEMENT	0	0		76.02
76.03	03954	INFUSION CENTER	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	3,170		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	44,705		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	44,705		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0100	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/28/2018 10:46 am
	Title XVIII	Hospital	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,913	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,913	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)	4,025	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,247	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)	16,442,149	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	16,442,149	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)	16,442,149	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	3,346.66	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,173,285	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	4,173,285	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/28/2018 10:46 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	10,373,271	4,540	2,284.86	330	754,004	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	6,966,366	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	11,893,655	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)	1,172,195	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	808,852	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,981,047	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	9,912,608	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)	888	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	3,346.66	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,971,834	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/28/2018 10:46 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	4,109,460	16,442,149	0.249934	2,971,834	742,762	90.00
91.00	Nursing School cost	0	16,442,149	0.000000	2,971,834	0	91.00
92.00	Allied health cost	0	16,442,149	0.000000	2,971,834	0	92.00
93.00	All other Medical Education	0	16,442,149	0.000000	2,971,834	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/28/2018 10:46 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,274,202		30.00
31.00	03100	INTENSIVE CARE UNIT		2,622,504		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0		34.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.201117	6,639,318	1,335,280	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.237188	1,064,770	252,551	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.184358	403,820	74,447	55.00
56.00	05600	RADIOISOTOPE	0.226172	32,023	7,243	56.00
57.00	05700	CT SCAN	0.029182	995,437	29,049	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.136839	370,591	50,711	58.00
60.00	06000	LABORATORY	0.151372	2,734,955	413,996	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.219095	656,103	143,749	63.00
64.00	06400	INTRAVENOUS THERAPY	0.191169	3,507	670	64.00
65.00	06500	RESPIRATORY THERAPY	0.553331	268,994	148,843	65.00
66.00	06600	PHYSICAL THERAPY	0.903359	344,237	310,970	66.00
69.00	06900	ELECTROCARDIOLOGY	0.178345	360,610	64,313	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.632071	2,914,134	1,841,940	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.197404	9,345,910	1,844,920	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	0.734326	33,918	24,907	76.01
76.02	03952	PAIN MANAGEMENT	0.000000	0	0	76.02
76.03	03954	INFUSION CENTER	0.000000	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.058350	15,010	30,896	90.00
91.00	09100	EMERGENCY	0.751337	261,386	196,389	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.323662	147,690	195,492	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		26,592,413	6,966,366	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		26,592,413		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0100	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 11/28/2018 10:46 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	873,398	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	2,202,949	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	3,022,136	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	70.57	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.00	30.00
31.00	Percentage of Medicaid patient days (see instructions)	0.00	31.00
32.00	Sum of lines 30 and 31	0.00	32.00
33.00	Allowable disproportionate share percentage (see instructions)	0.00	33.00
34.00	Disproportionate share adjustment (see instructions)	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E Part A Date/Time Prepared: 11/28/2018 10:46 am

Title XVIII | Hospital | PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	0		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	6,098,483		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		6,098,483	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		631,790	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		6,730,273	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		6,730,273	61.00
62.00	Deductibles billed to program beneficiaries		249,664	62.00
63.00	Coinsurance billed to program beneficiaries		28,325	63.00
64.00	Allowable bad debts (see instructions)		35,936	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		23,358	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		2,655	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		6,475,642	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		31,968	70.93
70.94	HRR adjustment amount (see instructions)		0	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0100	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 11/28/2018 10:46 am
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		21,495	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		6,486,115	71.00
71.01	Sequestration adjustment (see instructions)		129,722	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		6,338,937	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		17,456	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/28/2018 10:46 am

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (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	873,398	873,398		873,398	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,202,949		2,202,949	2,202,949	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	3,022,136	1,059,420	1,962,716	3,022,136	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	6,098,483	1,932,818	4,165,665	6,098,483	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	6,098,483	1,932,818	4,165,665	6,098,483	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	631,790	199,687	432,103	631,790	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			2,132,505	4,597,768	6,730,273	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/28/2018 10:46 am

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	250,112	70,693	179,419	250,112	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	381,678	128,994	252,684	381,678	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	631,790	199,687	432,103	631,790	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	31,968	17,012	14,956	31,968	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		21,495	0	21,495	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0100	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/28/2018 10:46 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	44,705	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	34,290,847	2.00
3.00	OPPS payments	20,332,491	3.00
4.00	Outlier payment (see instructions)	915,727	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)	44,705	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	211,944	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)	211,944	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 chargebasis 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)	211,944	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	167,239	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)	44,705	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)	21,248,218	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)	3,277,769	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)	18,015,154	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	18,015,154	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	18,015,154	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)	403,725	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	262,421	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	20,159	36.00
37.00	Subtotal (see instructions)	18,277,575	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment 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)	18,277,575	40.00
40.01	Sequestration adjustment (see instructions)	365,552	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	17,727,506	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	184,517	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: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 11/28/2018 10:46 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		6,338,937		17,727,506	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)		6,338,937		17,727,506	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		17,456		184,517	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		6,356,393		17,912,023	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: 14-0100	Period: From 07/01/2017 To 06/30/2018	Worksheet E-1 Part II Date/Time Prepared: 11/28/2018 10:46 am
	Title XVIII	Hospital	PPS

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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G | Date/Time Prepared: 11/28/2018 10:46 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	0	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	0	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	0	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	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	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	0	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	0	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	0	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				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	0	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)	0	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	0				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	0	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	0	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-1 | Date/Time Prepared: 11/28/2018 10:46 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-429,863,075				2.00
3.00	Total (sum of line 1 and line 2)		-429,863,075		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-429,863,075		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-429,863,075		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			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: 14-0100 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/28/2018 10:46 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	0		0	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)	0		0	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT	0		0	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	0		0	17.00
18.00	Ancillary services	0	0	0	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				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	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	0	0	0	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		429,863,075		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)		429,863,075		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-0100	Period: From 07/01/2017 To 06/30/2018	Worksheet G-3 Date/Time Prepared: 11/28/2018 10:46 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	0	1.00
2.00	Less contractual allowances and discounts on patients' accounts	0	2.00
3.00	Net patient revenues (line 1 minus line 2)	0	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	429,863,075	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-429,863,075	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	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	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	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	OTHER (SPECIFY)	0	24.00
25.00	Total other income (sum of lines 6-24)	0	25.00
26.00	Total (line 5 plus line 25)	-429,863,075	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)	-429,863,075	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0100	Period: From 07/01/2017 To 06/30/2018	Worksheet L Parts I-III Date/Time Prepared: 11/28/2018 10:46 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	250,112	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	381,678	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	23.47	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	631,790	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00