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: 14-0124	Period: From 12/01/2017 To 11/30/2018	Worksheet S Parts I-III Date/Time Prepared: 12/21/2018 2:13 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: — Time:
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 JOHN H. STROGER JR. HOSP OF COOK CTY (14-0124) for the cost reporting period beginning 12/01/2017 and ending 11/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

CHIEF FINANCIAL OFFICER
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	9,414,890	1,411,511	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	9,414,890	1,411,511	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: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 12/21/2018 2:13 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1901 WEST HARRISON STREET	PO Box:			1.00
2.00	City: CHICAGO	State: IL	Zip Code: 60612-3714	County: COOK	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	JOHN H. STROGER JR. HOSP OF COOK CTY	140124	16974	1	07/01/1966	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	JOHN H. STROGER JR. HOSP DIALYSIS	142313	16794		07/01/1973				18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	12/01/2017	11/30/2018	20.00
21.00	Type of Control (see instructions)	9		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	1	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.	16,002	3,112	0	0	14,530	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 12/21/2018 2:13 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	Y			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	Y			60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1	60.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 12/21/2018 2:13 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 12/21/2018 2:13 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

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				1.00	
	Long Term Care Hospital PPS				
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			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	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	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.		N	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.		N	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.		N	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.		N	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: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 12/21/2018 2:13 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	1,664,089	12,286,870	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.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

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	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: COOK COUNTY	Contractor's Name:	Contractor's Number: 00131	141.00
142.00	Street: 118 NORTH CLARK STREET	PO Box:		142.00
143.00	City: CHICAGO	State: IL	Zip Code: 60602	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N	Y	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	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)	9.99	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2017	09/30/2018	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: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet S-2 Part II Date/Time Prepared: 12/21/2018 2:13 pm

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

		Y/N	Date	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)	N			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		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	Y		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	Y		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)	Y	12/03/2018	Y	12/03/2018	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	Y		Y		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet S-2 Part II Date/Time Prepared: 12/21/2018 2:13 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions					22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.					23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions					24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.					25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.					26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.					27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.					28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions					29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.					30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.					32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.					34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.					35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?					36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MICHAEL		SUMRALL		41.00
42.00	Enter the employer/company name of the cost report preparer.	COOK COUNTY HEALTH & HOSPITAL SYSTEM				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	312-864-4776		MSUMRALL@COOKCOUNTYHHS.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0124	Period: From 12/01/2017 To 11/30/2018	Worksheet S-2 Part II Date/Time Prepared: 12/21/2018 2:13 pm

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

HFS Supplemental Information | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet S-2 Part IX Date/Time Prepared: 12/21/2018 2:13 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet S-3 Part I Date/Time Prepared: 12/21/2018 2:13 pm

	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	310	113,150	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)		310	113,150	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	32	11,680	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT	33.00	8	2,920	0.00	0	10.00
11.00	SURGICAL INTENSIVE CARE UNIT	34.00	14	5,110	0.00	0	11.00
11.01	PEDIATRIC INTENSIVE CARE UNIT	34.01	10	3,650	0.00	0	11.01
11.02	TRAUMA INTENSIVE CARE UNIT	34.02	12	4,380	0.00	0	11.02
11.03	NEURO INTENSIVE CARE	34.03	10	3,650	0.00	0	11.03
11.04	NEONATAL INTENSIVE CARE UNIT	34.04	52	18,980	0.00	0	11.04
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		448	163,520	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)		448				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)		9	3,285			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

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	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)	8,286	11,716	58,913			1.00
2.00	HMO and other (see instructions)	2,891	14,530				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)	8,286	11,716	58,913			7.00
8.00	INTENSIVE CARE UNIT	1,482	1,665	8,163			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT	249	159	1,432			10.00
11.00	SURGICAL INTENSIVE CARE UNIT	401	441	2,665			11.00
11.01	PEDIATRIC INTENSIVE CARE UNIT	0	373	1,251			11.01
11.02	TRAUMA INTENSIVE CARE UNIT	181	357	2,033			11.02
11.03	NEURO INTENSIVE CARE	198	277	2,024			11.03
11.04	NEONATAL INTENSIVE CARE UNIT	0	3,165	7,036			11.04
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		961	1,763			13.00
14.00	Total (see instructions)	10,797	19,114	85,280	473.79	4,822.12	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)				473.79	4,822.12	27.00
28.00	Observation Bed Days		0	18,487			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	1,068			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: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 12/21/2018 2:13 pm

	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	1,828	3,621	15,967	1.00
2.00	HMO and other (see instructions)			547	2,247		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
11.01	PEDIATRIC INTENSIVE CARE UNIT						11.01
11.02	TRAUMA INTENSIVE CARE UNIT						11.02
11.03	NEURO INTENSIVE CARE						11.03
11.04	NEONATAL INTENSIVE CARE UNIT						11.04
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,828	3,621	15,967	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: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet S-3 Part II Date/Time Prepared: 12/21/2018 2:13 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	454,759,227	-3,081,556	451,677,671	10,030,002.00	45.03	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		1,834,409	0	1,834,409	21,960.00	83.53	3.00
4.00	Physician-Part A - Administrative		51,760,297	0	51,760,297	353,419.00	146.46	4.00
4.01	Physicians - Part A - Teaching		7,569,827	0	7,569,827	65,825.00	115.00	4.01
5.00	Physician and Non Physician-Part B		82,982,825	0	82,982,825	759,636.00	109.24	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	23,598,403	6,161,596	29,759,999	864,529.00	34.42	7.00
7.01	Contracted interns and residents (in an approved programs)		4,258,020	0	4,258,020	102,258.00	41.64	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)		0	875,286	875,286	17,723.00	49.39	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		16,739,021	0	16,739,021	287,460.00	58.23	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		51,080,394	0	51,080,394	1,262,180.00	40.47	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)		77,006,595	0	77,006,595			17.00
18.00	Wage-related costs (other) (see instructions)		9,707,052	0	9,707,052			18.00
19.00	Excluded areas		240,416	0	240,416			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		498,361	0	498,361			21.00
22.00	Physician Part A - Administrative		15,818,368	0	15,818,368			22.00
22.01	Physician Part A - Teaching		2,333,750	0	2,333,750			22.01
23.00	Physician Part B		25,597,081	0	25,597,081			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		12,595,453	0	12,595,453			25.00
25.50	Home office wage-related (core)		9,806,174	0	9,806,174			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	2,054,356	0	2,054,356	84,337.00	24.36	26.00
27.00	Administrative & General	5.00	39,951,416	399,320	40,350,736	972,605.00	41.49	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet S-3 Part II Date/Time Prepared: 12/21/2018 2:13 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		523,420	0	523,420	9,888.00	52.93	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	16,272,766	0	16,272,766	366,446.00	44.41	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	7,538,197	0	7,538,197	347,653.00	21.68	32.00
33.00	Housekeeping under contract (see instructions)		474,997	0	474,997	20,729.00	22.91	33.00
34.00	Dietary	10.00	4,284,035	-2,574,354	1,709,681	66,817.00	25.59	34.00
35.00	Dietary under contract (see instructions)		724,293	0	724,293	31,608.00	22.91	35.00
36.00	Cafeteria	11.00	0	2,574,354	2,574,354	124,529.00	20.67	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	3,263,238	0	3,263,238	153,668.00	21.24	38.00
39.00	Central Services and Supply	14.00	3,921,081	0	3,921,081	171,497.00	22.86	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	3,786,686	0	3,786,686	116,927.00	32.39	41.00
42.00	Social Service	17.00	205,865	-44,834	161,031	6,305.00	25.54	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet S-3 Part III Date/Time Prepared: 12/21/2018 2:13 pm

		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)		336,238,453	-9,243,152	326,995,301	8,278,019.00	39.50	1.00
2.00	Excluded area salaries (see instructions)		0	875,286	875,286	17,723.00	49.39	2.00
3.00	Subtotal salaries (line 1 minus line 2)		336,238,453	-10,118,438	326,120,015	8,260,296.00	39.48	3.00
4.00	Subtotal other wages & related costs (see inst.)		67,819,415	0	67,819,415	1,549,640.00	43.76	4.00
5.00	Subtotal wage-related costs (see inst.)		112,338,189	0	112,338,189	0.00	34.45	5.00
6.00	Total (sum of lines 3 thru 5)		516,396,057	-10,118,438	506,277,619	9,809,936.00	51.61	6.00
7.00	Total overhead cost (see instructions)		83,000,350	354,486	83,354,836	2,473,009.00	33.71	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet S-3 Part IV Date/Time Prepared: 12/21/2018 2:13 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	51,324,804	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)	44,439,879	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	16,081,412	9.00
10.00	Dental, Hearing and Vision Plan	2,387,506	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	616,140	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	3,927,608	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	4,361,216	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	326,387	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	918,020	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	124,382,972	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED - MALPRACTICE EXP	9,707,052	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet S-3 Part V Date/Time Prepared: 12/21/2018 2:13 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	16,739,021	124,382,972	1.00
2.00	Hospital	16,739,021	77,006,595	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	0	0	17.00
18.00	Other	0	47,376,377	18.00

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet S-5 | Date/Time Prepared: 12/21/2018 2:13 pm

		Outpatient		Training		Home		
		Regular	High Flux	Hemodialysis	CAPD / CCPD	Hemodialysis	CAPD / CCPD	
		1.00	2.00	3.00	4.00	5.00	6.00	
1.00	Number of patients in program at end of cost reporting period	29	0	0	0	0	0	1.00
2.00	Number of times per week patient receives dialysis	3.50	0.00	0.00	0.00	0.00	0.00	2.00
3.00	Average patient dialysis time including setup	5.00	0.00	0.00	0.00			3.00
4.00	CAPD exchanges per day				0.00		0.00	4.00
5.00	Number of days in year dialysis furnished	312	0					5.00
6.00	Number of stations	8	0	0	0			6.00
7.00	Treatment capacity per day per station	4	0					7.00
8.00	Utilization (see instructions)	0.00	0.00					8.00
9.00	Average times dialyzers re-used	0.00	0.00					9.00
10.00	Percentage of patients re-using dialyzers	0.00	0.00					10.00

		Y/N	
		1.00	
	ESRD PPS		
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter "Y" for yes or "N" for no. (see instructions)	N	10.01
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter "Y" for yes or "N" for no. (See instructions for "new" providers.)	Y	10.02

		Prior to 1/1	After 12/31	
		1.00	2.00	
10.03	If you responded "N" to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)	0	0	10.03
	TRANSPLANT INFORMATION			
11.00	Number of patients on transplant list	0		11.00
12.00	Number of patients transplanted during the cost reporting period	0		12.00
	EPOETIN			
13.00	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider.			13.00
14.00	Epoetin amount from Worksheet A for Home Dialysis program			14.00
15.00	Number of EPO units furnished relating to the renal dialysis department			15.00
16.00	Number of EPO units furnished relating to the home dialysis department			16.00
	ARANESP			
17.00	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider.			17.00
18.00	ARANESP amount from Worksheet A for Home Dialysis program			18.00
19.00	Number of ARANESP units furnished relating to the renal dialysis department			19.00
20.00	Number of ARANESP units furnished relating to the home dialysis department			20.00

		MCP	INITIAL METHOD	
		1.00	2.00	
	PHYSICIAN PAYMENT METHOD			
21.00	Enter "X" if method(s) is applicable		X	21.00

		ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.	
		1.00	2.00	3.00	4.00	5.00	
	ESAs						
22.00	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)		0	0	0	0	22.00

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA	Provider CCN: 14-0124	Period: From 12/01/2017 To 11/30/2018	Worksheet S-5 Date/Time Prepared: 12/21/2018 2:13 pm

		CCN	Treatments	
		1.00	2.00	
23.00	If line 10.01 is yes, enter in column 1 the CCN for each renal dialysis facility listed on Worksheet S-2, Part I, line 18, and its subscripts. Enter in column 2, the total treatments for each CCN. (see instructions)	142313	5,660	23.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet S-10 | Date/Time Prepared: 12/21/2018 2:13 pm

		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)	0.729980	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	94,274,484	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	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	289,260,570	6.00
7.00	Medicaid cost (line 1 times line 6)	211,154,431	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)	116,879,947	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	2,577,907	9.00
10.00	Stand-alone CHIP charges	3,308,076	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	2,414,829	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)	1,475,919	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	2,846,633	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	2,077,985	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)	602,066	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)	117,482,013	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)	526,335,418	0	526,335,418	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	384,214,328	0	384,214,328	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)	384,214,328	0	384,214,328	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)	168,521,332	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	2,206,442	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	3,394,526	27.01
28.00	Non-Medicare bad debt expense (see instructions)	165,126,806	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	121,727,350	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	505,941,678	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	623,423,691	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet A | Date/Time Prepared: 12/21/2018 2:13 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		12,584,981	12,584,981	317,781	12,902,762	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		4,975,203	4,975,203	0	4,975,203	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,054,356	72,555,357	74,609,713	3,150,545	77,760,258	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	39,951,416	120,886,112	160,837,528	-2,969,293	157,868,235	5.00
7.00	00700	OPERATION OF PLANT	16,272,766	16,767,080	33,039,846	0	33,039,846	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,787,756	2,787,756	0	2,787,756	8.00
9.00	00900	HOUSEKEEPING	7,538,197	1,132,070	8,670,267	474,997	9,145,264	9.00
10.00	01000	DIETARY	4,284,035	4,851,561	9,135,596	-6,064,454	3,071,142	10.00
11.00	01100	CAFETERIA	0	0	0	5,489,744	5,489,744	11.00
13.00	01300	NURSING ADMINISTRATION	3,263,238	4,376,517	7,639,755	0	7,639,755	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,921,081	19,943,528	23,864,609	0	23,864,609	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,786,686	2,425,147	6,211,833	0	6,211,833	16.00
17.00	01700	SOCIAL SERVICE	205,865	0	205,865	-44,834	161,031	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	23,598,403	2,917,399	26,515,802	6,161,596	32,677,398	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	1,538,390	1,727,250	3,265,640	10,032,289	13,297,929	22.00
23.00	02300	ALLIED HEALTH	0	0	0	204,180	204,180	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	62,434,441	6,801,945	69,236,386	-5,420,057	63,816,329	30.00
31.00	03100	INTENSIVE CARE UNIT	8,208,804	141,460	8,350,264	290,564	8,640,828	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	4,941,156	172,013	5,113,169	-10,815	5,102,354	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	3,601,613	85,435	3,687,048	-167,246	3,519,802	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	681,315	0	681,315	11,438	692,753	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	5,525,124	390,437	5,915,561	272,874	6,188,435	34.02
34.03	02400	NEURO INTENSIVE CARE	2,516,865	30,984	2,547,849	44,165	2,592,014	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	7,692,156	28,882	7,721,038	-538,788	7,182,250	34.04
43.00	04300	NURSERY	2,243,425	44,860	2,288,285	0	2,288,285	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	39,548,078	18,138,984	57,687,062	-2,211,831	55,475,231	50.00
51.00	05100	RECOVERY ROOM	3,681,192	14,806	3,695,998	0	3,695,998	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,783,049	49,016	3,832,065	75,032	3,907,097	52.00
53.00	05300	ANESTHESIOLOGY	11,065,150	318,616	11,383,766	-1,225,659	10,158,107	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,568,603	12,123,639	31,692,242	-69,007	31,623,235	54.00
60.00	06000	LABORATORY	16,701,833	18,308,429	35,010,262	-331,514	34,678,748	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,023,563	3,828,306	4,851,869	0	4,851,869	62.00
65.00	06500	RESPIRATORY THERAPY	8,124,495	981,486	9,105,981	-687,606	8,418,375	65.00
66.00	06600	PHYSICAL THERAPY	2,179,258	355,657	2,534,915	0	2,534,915	66.00
67.00	06700	OCCUPATIONAL THERAPY	761,562	729	762,291	0	762,291	67.00
68.00	06800	SPEECH PATHOLOGY	423,753	0	423,753	0	423,753	68.00
69.00	06900	ELECTROCARDIOLOGY	6,627,436	3,145,753	9,773,189	-695,478	9,077,711	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,663,459	7,663,459	-4,165,284	3,498,175	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,165,284	4,165,284	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,754,047	73,793,995	95,548,042	-209,833	95,338,209	73.00
74.00	07400	RENAL DIALYSIS	3,993,916	180,914	4,174,830	0	4,174,830	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	80,287,554	39,254,739	119,542,293	-5,194,303	114,347,990	90.00
91.00	09100	EMERGENCY	30,976,406	1,234,949	32,211,355	-1,355,593	30,855,762	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	454,759,227	455,019,454	909,778,681	-671,106	909,107,575	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	0	0	0	671,106	671,106	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	COUNTYCARE	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	454,759,227	455,019,454	909,778,681	0	909,778,681	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet A | Date/Time Prepared: 12/21/2018 2:13 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	38,354,566	51,257,328		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	11,082,406	16,057,609		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	52,027,322	129,787,580		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	134,295,542	292,163,777		5.00
7.00	00700	OPERATION OF PLANT	-3,317,203	29,722,643		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,787,756		8.00
9.00	00900	HOUSEKEEPING	0	9,145,264		9.00
10.00	01000	DIETARY	0	3,071,142		10.00
11.00	01100	CAFETERIA	0	5,489,744		11.00
13.00	01300	NURSING ADMINISTRATION	-242,588	7,397,167		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	23,864,609		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-142,610	6,069,223		16.00
17.00	01700	SOCIAL SERVICE	-114,763	46,268		17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	32,677,398		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	-9,789,354	3,508,575		22.00
23.00	02300	ALLIED HEALTH	0	204,180		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-19,922,697	43,893,632		30.00
31.00	03100	INTENSIVE CARE UNIT	0	8,640,828		31.00
33.00	03300	BURN INTENSIVE CARE UNIT	-253,117	4,849,237		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	-274,203	3,245,599		34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	-627,473	65,280		34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	-1,005,541	5,182,894		34.02
34.03	02400	NEURO INTENSIVE CARE	0	2,592,014		34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	-3,524,865	3,657,385		34.04
43.00	04300	NURSERY	0	2,288,285		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-18,179,247	37,295,984		50.00
51.00	05100	RECOVERY ROOM	0	3,695,998		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,907,097		52.00
53.00	05300	ANESTHESIOLOGY	-5,775,994	4,382,113		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-5,275,194	26,348,041		54.00
60.00	06000	LABORATORY	-2,061,251	32,617,497		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	4,851,869		62.00
65.00	06500	RESPIRATORY THERAPY	-3,041,446	5,376,929		65.00
66.00	06600	PHYSICAL THERAPY	0	2,534,915		66.00
67.00	06700	OCCUPATIONAL THERAPY	-209,460	552,831		67.00
68.00	06800	SPEECH PATHOLOGY	0	423,753		68.00
69.00	06900	ELECTROCARDIOLOGY	-2,263,583	6,814,128		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,498,175		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,165,284		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,828,147	97,166,356		73.00
74.00	07400	RENAL DIALYSIS	-1,416,654	2,758,176		74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-16,786,534	97,561,456		90.00
91.00	09100	EMERGENCY	-4,944,297	25,911,465		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	138,419,909	1,047,527,484		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.03	19003	SPECIAL FUNDS	0	671,106		190.03
190.04	19004	SENGSTACKE CLINIC	0	0		190.04
194.00	07950	COUNTYCARE	0	0		194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	138,419,909	1,048,198,590		200.00

COST CENTERS USED IN COST REPORT | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet Non-CMS W | Date/Time Prepared: 12/21/2018 2:13 pm

	Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
21.00	I&R SERVICES-SALARY & FRINGES APPRV	02100		21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	02200		22.00
23.00	ALLIED HEALTH	02300		23.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
33.00	BURN INTENSIVE CARE UNIT	03300		33.00
34.00	SURGICAL INTENSIVE CARE UNIT	03400		34.00
34.01	PEDIATRIC INTENSIVE CARE UNIT	02080	PEDIATRIC INTENSIVE CARE UNIT	34.01
34.02	TRAUMA INTENSIVE CARE UNIT	02180	TRAUMA INTENSIVE CARE UNIT	34.02
34.03	NEURO INTENSIVE CARE	02400		34.03
34.04	NEONATAL INTENSIVE CARE UNIT	02060	NEONATAL INTENSIVE CARE UNIT	34.04
43.00	NURSERY	04300		43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
60.00	LABORATORY	06000		60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELL	06200		62.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
74.00	RENAL DIALYSIS	07400		74.00
	OUTPATIENT SERVICE COST CENTERS			
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	09200		92.00
	SPECIAL PURPOSE COST CENTERS			
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)			118.00
	NONREIMBURSABLE COST CENTERS			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
190.03	SPECIAL FUNDS	19003		190.03
190.04	SENGSTACKE CLINIC	19004		190.04
194.00	COUNTYCARE	07950		194.00
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

RECLASSIFICATIONS | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet A-6 | Date/Time Prepared: 12/21/2018 2:13 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - Fringe Benefits to EHW				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,150,545	1.00
	TOTALS		0	3,150,545	
	B - Service Contracts				
1.00	HOUSEKEEPING	9.00	0	474,997	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	99,713	2.00
	TOTALS		0	574,710	
	C - Sal of Non Residents				
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	2,898,547		1.00
			2,898,547	0	
	D - Peds Algy & Psych to Inp				
1.00	ADULTS & PEDIATRICS	30.00	225,553	802	1.00
			225,553	802	
	E - Registry and In-House Nsg				
1.00	INTENSIVE CARE UNIT	31.00	124,703	165,861	1.00
2.00	BURN INTENSIVE CARE UNIT	33.00	5,525	25,874	2.00
3.00	SURGICAL INTENSIVE CARE UNIT	34.00	5,525	19,142	3.00
4.00	PEDIATRIC INTENSIVE CARE UNIT	34.01	0	11,438	4.00
5.00	TRAUMA INTENSIVE CARE UNIT	34.02	14,880	306,665	5.00
6.00	NEURO INTENSIVE CARE	34.03	2,495	41,670	6.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	10,826	64,206	7.00
8.00	EMERGENCY	91.00	0	2,178	8.00
9.00	CLINIC	90.00	0	4,358	9.00
10.00	NEONATAL INTENSIVE CARE UNIT	34.04	0	3,268	10.00
	TOTALS		163,954	644,660	
	F - Dietary/Cafeteria				
1.00	CAFETERIA	11.00	2,574,354	2,915,390	1.00
			2,574,354	2,915,390	
	G - Hektoen Cost to Research				
1.00	SPECIAL FUNDS	190.03	671,106	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	TOTALS		671,106	0	
	H - Implants				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00		4,165,284	1.00
			0	4,165,284	
	I - HBP Teaching Time				
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	7,569,826	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	TOTALS		7,569,826	0	
	J - Sengstacke				
1.00	CLINIC	90.00		3,081,556	1.00
			0	3,081,556	
	K - Insurance Reclass				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	317,781	1.00
	TOTALS		0	317,781	
	L - Pharmacy School				
1.00	ALLIED HEALTH	23.00	204,180		1.00
			204,180	0	
	M - Medical Director				
1.00	ADMINISTRATIVE & GENERAL	5.00	436,084		1.00
			436,084	0	
	N - I&R Salaries				
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	9,060,143		1.00
2.00					2.00
3.00					3.00
4.00					4.00
5.00					5.00
6.00					6.00
7.00					7.00
8.00					8.00
9.00					9.00
10.00					10.00
11.00					11.00

RECLASSIFICATIONS | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet A-6 | Date/Time Prepared: 12/21/2018 2:13 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
12.00						12.00
13.00						13.00
			9,060,143	0		
500.00	Grand Total: Increases		23,803,747	14,850,728		500.00

RECLASSIFICATIONS | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet A-6 | Date/Time Prepared: 12/21/2018 2:13 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - Fringe Benefits to EHW						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,150,545	0		1.00
	TOTALS		0	3,150,545			
	B - Service Contracts						
1.00	DIETARY	10.00	0	574,710	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	574,710			
	C - Sal of Non Residents						
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	2,898,547				1.00
			2,898,547	0			
	D - Peds Algy & Psych to Inp						
1.00	CLINIC	90.00	225,553	802			1.00
			225,553	802			
	E - Registry and In-House Nsg						
1.00	ADULTS & PEDIATRICS	30.00	163,954	644,660	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
	TOTALS		163,954	644,660			
	F - Dietary/Cafeteria						
1.00	DIETARY	10.00	2,574,354	2,915,390			1.00
			2,574,354	2,915,390			
	G - Hektoen Cost to Research						
1.00	ADMINISTRATIVE & GENERAL	5.00	36,764	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	580,390	0	0		2.00
3.00	ANESTHESIOLOGY	53.00	16,686	0	0		3.00
4.00	CLINIC	90.00	31,613	0	0		4.00
5.00	DRUGS CHARGED TO PATIENTS	73.00	5,653	0	0		5.00
	TOTALS		671,106	0			
	H - Implants						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00		4,165,284			1.00
			0	4,165,284			
	I - HBP Teaching Time						
1.00	ADULTS & PEDIATRICS	30.00	2,623,369	0	0		1.00
2.00	ANESTHESIOLOGY	53.00	1,030,835	0	0		2.00
3.00	LABORATORY	60.00	331,514	0	0		3.00
4.00	CLINIC	90.00	2,359,381	0	0		4.00
5.00	EMERGENCY	91.00	1,224,727	0	0		5.00
	TOTALS		7,569,826	0			
	J - Sengstacke						
1.00	CLINIC	90.00	3,081,556				1.00
			3,081,556	0			
	K - Insurance Reclass						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	317,781	12		1.00
	TOTALS		0	317,781			
	L - Pharmacy School						
1.00	DRUGS CHARGED TO PATIENTS	73.00	204,180				1.00
			204,180	0			
	M - Medical Director						
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	436,084				1.00
			436,084	0			
	N - I&R Salaries						
1.00	SOCIAL SERVICE	17.00	44,834				1.00
2.00	ADULTS & PEDIATRICS	30.00	1,634,039				2.00
3.00	BURN INTENSIVE CARE UNIT	33.00	42,214				3.00
4.00	SURGICAL INTENSIVE CARE UNIT	34.00	191,913				4.00
5.00	TRAUMA INTENSIVE CARE UNIT	34.02	48,671				5.00
6.00	NEONATAL INTENSIVE CARE UNIT	34.04	542,056				6.00
7.00	OPERATING ROOM	50.00	2,211,831				7.00
8.00	ANESTHESIOLOGY	53.00	178,138				8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	69,007				9.00
10.00	RESPIRATORY THERAPY	65.00	687,606				10.00
11.00	ELECTROCARDIOLOGY	69.00	695,478				11.00
12.00	CLINIC	90.00	2,581,312				12.00
13.00	EMERGENCY	91.00	133,044				13.00

RECLASSIFICATIONS | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet A-6 | Date/Time Prepared: 12/21/2018 2:13 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
			9,060,143	0			
500.00	Grand Total: Decreases		26,885,303	11,769,172			500.00

RECLASSIFICATIONS | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 12/21/2018 2:13 pm

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
	A - Fringe Benefits to EHW								
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,150,545	ADMINISTRATIVE & GENERAL	5.00	0	3,150,545	1.00
	TOTALS		0	3,150,545	TOTALS		0	3,150,545	
	B - Service Contracts								
1.00	HOUSEKEEPING	9.00	0	474,997	DIETARY	10.00	0	574,710	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	99,713		0.00	0	0	2.00
	TOTALS		0	574,710	TOTALS		0	574,710	
	C - Sal of Non Residents								
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	2,898,547		I&R SERVICES-SALARY & FRINGES APPRV	21.00	2,898,547		1.00
			2,898,547	0			2,898,547	0	
	D - Peds Algy & Psych to Inp								
1.00	ADULTS & PEDIATRICS	30.00	225,553	802	CLINIC	90.00	225,553	802	1.00
			225,553	802			225,553	802	
	E - Registry and In-House Nsg								
1.00	INTENSIVE CARE UNIT	31.00	124,703	165,861	ADULTS & PEDIATRICS	30.00	163,954	644,660	1.00
2.00	BURN INTENSIVE CARE UNIT	33.00	5,525	25,874		0.00	0	0	2.00
3.00	SURGICAL INTENSIVE CARE UNIT	34.00	5,525	19,142		0.00	0	0	3.00
4.00	PEDIATRIC INTENSIVE CARE UNIT	34.01	0	11,438		0.00	0	0	4.00
5.00	TRAUMA INTENSIVE CARE UNIT	34.02	14,880	306,665		0.00	0	0	5.00
6.00	NEURO INTENSIVE CARE	34.03	2,495	41,670		0.00	0	0	6.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	10,826	64,206		0.00	0	0	7.00
8.00	EMERGENCY	91.00	0	2,178		0.00	0	0	8.00
9.00	CLINIC	90.00	0	4,358		0.00	0	0	9.00
10.00	NEONATAL INTENSIVE CARE UNIT	34.04	0	3,268		0.00	0	0	10.00
	TOTALS		163,954	644,660	TOTALS		163,954	644,660	
	F - Dietary/Cafeteria								
1.00	CAFETERIA	11.00	2,574,354	2,915,390	DIETARY	10.00	2,574,354	2,915,390	1.00
			2,574,354	2,915,390			2,574,354	2,915,390	
	G - Hektoen Cost to Research								
1.00	SPECIAL FUNDS	190.03	671,106	0	ADMINISTRATIVE & GENERAL	5.00	36,764	0	1.00
2.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	580,390	0	2.00
3.00		0.00	0	0	ANESTHESIOLOGY	53.00	16,686	0	3.00
4.00		0.00	0	0	CLINIC	90.00	31,613	0	4.00
5.00		0.00	0	0	DRUGS CHARGED TO PATIENTS	73.00	5,653	0	5.00
	TOTALS		671,106	0	TOTALS		671,106	0	
	H - Implants								
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00		4,165,284	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00		4,165,284	1.00
			0	4,165,284			0	4,165,284	
	I - HBP Teaching Time								
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	7,569,826	0	ADULTS & PEDIATRICS	30.00	2,623,369	0	1.00
2.00		0.00	0	0	ANESTHESIOLOGY	53.00	1,030,835	0	2.00
3.00		0.00	0	0	LABORATORY	60.00	331,514	0	3.00
4.00		0.00	0	0	CLINIC	90.00	2,359,381	0	4.00
5.00		0.00	0	0	EMERGENCY	91.00	1,224,727	0	5.00
	TOTALS		7,569,826	0	TOTALS		7,569,826	0	
	J - Sengstacke								
1.00	CLINIC	90.00		3,081,556	CLINIC	90.00	3,081,556		1.00
			0	3,081,556			3,081,556	0	
	K - Insurance Reclass								
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	317,781	ADMINISTRATIVE & GENERAL	5.00	0	317,781	1.00
	TOTALS		0	317,781	TOTALS		0	317,781	
	L - Pharmacy School								
1.00	ALLIED HEALTH	23.00	204,180		DRUGS CHARGED TO PATIENTS	73.00	204,180		1.00
			204,180	0			204,180	0	
	M - Medical Director								
1.00	ADMINISTRATIVE & GENERAL	5.00	436,084		I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	436,084		1.00
			436,084	0			436,084	0	

RECLASSIFICATIONS | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 12/21/2018 2:13 pm

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
	N - I&R Salaries								
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	9,060,143		SOCIAL SERVICE	17.00	44,834		1.00
2.00					ADULTS & PEDIATRICS	30.00	1,634,039		2.00
3.00					BURN INTENSIVE CARE UNIT	33.00	42,214		3.00
4.00					SURGICAL INTENSIVE CARE UNIT	34.00	191,913		4.00
5.00					TRAUMA INTENSIVE CARE UNIT	34.02	48,671		5.00
6.00					NEONATAL INTENSIVE CARE UNIT	34.04	542,056		6.00
7.00					OPERATING ROOM	50.00	2,211,831		7.00
8.00					ANESTHESIOLOGY	53.00	178,138		8.00
9.00					RADIOLOGY-DIAGNOSTIC	54.00	69,007		9.00
10.00					RESPIRATORY THERAPY	65.00	687,606		10.00
11.00					ELECTROCARDIOLOGY	69.00	695,478		11.00
12.00					CLINIC	90.00	2,581,312		12.00
13.00					EMERGENCY	91.00	133,044		13.00
			9,060,143	0			9,060,143	0	
500.00	Grand Total: Increases		23,803,747	14,850,728	Grand Total: Decreases		26,885,303	11,769,172	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet A-7 Part I Date/Time Prepared: 12/21/2018 2:13 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	990,911	0	0	0	0	1.00
2.00	Land Improvements	2,717,512	0	0	0	0	2.00
3.00	Buildings and Fixtures	632,961,859	70,363,132	0	70,363,132	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	20,776,061	0	0	0	0	5.00
6.00	Movable Equipment	172,761,545	54,043	0	54,043	0	6.00
7.00	HIT designated Assets	10,641,119	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	840,849,007	70,417,175	0	70,417,175	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	840,849,007	70,417,175	0	70,417,175	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	990,911	0	1.00
2.00	Land Improvements	2,717,512	0	2.00
3.00	Buildings and Fixtures	703,324,991	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	20,776,061	0	5.00
6.00	Movable Equipment	172,815,588	0	6.00
7.00	HIT designated Assets	10,641,119	0	7.00
8.00	Subtotal (sum of lines 1-7)	911,266,182	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	911,266,182	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet A-7 Part II | Date/Time Prepared: 12/21/2018 2:13 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	12,584,981	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,975,203	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	17,560,184	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	12,584,981		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4,975,203		2.00
3.00	Total (sum of lines 1-2)	0	17,560,184		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet A-7 Part III Date/Time Prepared: 12/21/2018 2:13 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	727,809,475	0	727,809,475	0.798679	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	183,456,707	0	183,456,707	0.201321	0	2.00
3.00	Total (sum of lines 1-2)	911,266,182	0	911,266,182	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	12,083,577	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	4,975,203	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	17,058,780	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	38,855,970	317,781	0	0	51,257,328	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	11,082,406	0	0	0	16,057,609	2.00
3.00	Total (sum of lines 1-2)	49,938,376	317,781	0	0	67,314,937	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet A-8 | Date/Time Prepared: 12/21/2018 2:13 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-294,745	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)	B	-3,317,203	OPERATION OF PLANT	7.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-72,937,590			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	116,941,877			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-30,845	LABORATORY	60.00	0	16.00
17.00	Sale of drugs to other than patients	B	-237,177	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-142,610	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	Miscellaneous Income	B	-257,256	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet A-8 | Date/Time Prepared: 12/21/2018 2:13 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	Residency Program Reimbursement	B	-7,570,702	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	33.01
33.02	County Adj for Hospital Bond Int.	A	39,150,715	CAP REL COSTS-BLDG & FIXT	1.00	11	33.02
33.03	County Adj for Hospital Bond Int.	A	11,082,406	CAP REL COSTS-MVBLE EQUIP	2.00	11	33.03
33.04	County Adj for Hospital Bond Int.	A	9,187,558	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	CRNA Costs	A	-1,834,409	ANESTHESIOLOGY	53.00	0	33.05
33.06	Remove Sengstacke Clinic	A	-678,274	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.06
33.07	Remove Sengstacke Clinic	A	10,795	DRUGS CHARGED TO PATIENTS	73.00	0	33.07
33.08	Remove Sengstacke Clinic	A	-3,134,476	CLINIC	90.00	0	33.08
33.09	IHA Lobbying	A	-96,181	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	Non-physician Part B	A	-242,623	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	Non-physician Part B	A	-387,682	NURSING ADMINISTRATION	13.00	0	33.11
33.12	Non-physician Part B	A	-114,763	SOCIAL SERVICE	17.00	0	33.12
33.13	Non-physician Part B	A	-2,964,342	ADULTS & PEDIATRICS	30.00	0	33.13
33.14	Non-physician Part B	A	-125,734	NEONATAL INTENSIVE CARE UNIT	34.04	0	33.14
33.15	Non-physician Part B	A	-2,168,186	OPERATING ROOM	50.00	0	33.15
33.16	Non-physician Part B	A	-243,761	RESPIRATORY THERAPY	65.00	0	33.16
33.17	Non-physician Part B	A	-588,287	ELECTROCARDIOLOGY	69.00	0	33.17
33.18	Non-physician Part B	A	-129,151	RENAL DIALYSIS	74.00	0	33.18
33.19	Non-physician Part B	A	-2,553,486	CLINIC	90.00	0	33.19
33.20	Non-physician Part B	A	-961,004	EMERGENCY	91.00	0	33.20
33.21	Oak Forest Vacant Space	A	-501,404	CAP REL COSTS-BLDG & FIXT	1.00	9	33.21
33.22	Pension Adjustment	A	51,330,263	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.22
33.23	Hospital Insurance	A	13,950,959	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24	Physician Part C	A	-1,045,766	ADULTS & PEDIATRICS	30.00	0	33.24
33.25	Physician Part C	A	-36,680	ANESTHESIOLOGY	53.00	0	33.25
33.26	Physician Part C	A	-79,599	LABORATORY	60.00	0	33.26
33.27	Physician Part C	A	-216,457	CLINIC	90.00	0	33.27
33.28	Physician Part C	A	-344,271	EMERGENCY	91.00	0	33.28
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		138,419,909				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: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet A-8-1 | Date/Time Prepared: 12/21/2018 2:13 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	Store Room	3,220,307	3,220,307	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	Payroll	361,380	361,380	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	General Accounting	289,747	289,747	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	County Costs Allocated to CC	28,515,662	0	3.01
3.02	4.00	EMPLOYEE BENEFITS DEPARTMENT	System Health & Hospital	2,325,435	0	3.02
3.03	5.00	ADMINISTRATIVE & GENERAL	System Health & Hospital	83,901,157	0	3.03
3.04	13.00	NURSING ADMINISTRATION	System Health & Hospital	145,094	0	3.04
3.05	73.00	DRUGS CHARGED TO PATIENTS	System Health & Hospital	2,054,529	0	3.05
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			120,813,311	3,871,434	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	G	Cook County	1.00	Cook County	1.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	COUNTY OWNED				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: 14-0124	Period: From 12/01/2017 To 11/30/2018	Worksheet A-8-1 Date/Time Prepared: 12/21/2018 2:13 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	0	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
3.01	28,515,662	0		3.01
3.02	2,325,435	0		3.02
3.03	83,901,157	0		3.03
3.04	145,094	0		3.04
3.05	2,054,529	0		3.05
4.00	0	0		4.00
5.00	116,941,877			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet A-8-2 | Date/Time Prepared: 12/21/2018 2:13 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	707,479	707,479	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	906,357	906,357	0	0	0	2.00
3.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	8,981,113	1,411,286	7,569,827	211,500	65,825	3.00
4.00	30.00	ADULTS & PEDIATRICS	20,640,440	14,916,372	5,724,068	179,000	50,381	4.00
5.00	33.00	BURN INTENSIVE CARE UNIT	253,117	253,117	0	0	0	5.00
6.00	34.00	SURGICAL INTENSIVE CARE UNIT	274,203	274,203	0	0	0	6.00
7.00	34.01	PEDIATRIC INTENSIVE CARE UNIT	627,473	627,473	0	0	0	7.00
8.00	34.02	TRAUMA INTENSIVE CARE UNIT	1,005,541	1,005,541	0	0	0	8.00
9.00	34.04	NEONATAL INTENSIVE CARE UNIT	3,399,131	3,399,131	0	0	0	9.00
10.00	50.00	OPERATING ROOM	16,011,061	16,011,061	0	0	0	10.00
11.00	51.00	RECOVERY ROOM	0	0	0	0	0	11.00
12.00	53.00	ANESTHESIOLOGY	4,310,533	3,812,191	498,342	239,400	3,210	12.00
13.00	54.00	RADIOLOGY-DIAGNOSTIC	5,275,194	5,275,194	0	0	0	13.00
14.00	60.00	LABORATORY	2,425,287	1,950,807	474,480	260,300	4,027	14.00
15.00	65.00	RESPIRATORY THERAPY	2,797,685	2,797,685	0	0	0	15.00
16.00	67.00	OCCUPATIONAL THERAPY	209,460	209,460	0	0	0	16.00
17.00	69.00	ELECTROCARDIOLOGY	1,675,296	1,675,296	0	0	0	17.00
18.00	74.00	RENAL DIALYSIS	1,287,503	1,287,503	0	0	0	18.00
19.00	90.00	CLINIC	14,391,299	10,621,855	3,769,444	179,000	37,773	19.00
20.00	91.00	EMERGENCY	5,593,312	3,639,022	1,954,290	246,400	15,381	20.00
200.00			90,771,484	70,781,033	19,990,451		176,597	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	41,156	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	52,725	2.00
3.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	6,693,263	334,663	0	0	82,099	3.00
4.00	30.00	ADULTS & PEDIATRICS	4,335,673	216,784	0	0	1,414,158	4.00
5.00	33.00	BURN INTENSIVE CARE UNIT	0	0	0	0	14,725	5.00
6.00	34.00	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	15,951	6.00
7.00	34.01	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	36,502	7.00
8.00	34.02	TRAUMA INTENSIVE CARE UNIT	0	0	0	0	58,495	8.00
9.00	34.04	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	197,737	9.00
10.00	50.00	OPERATING ROOM	0	0	0	0	931,410	10.00
11.00	51.00	RECOVERY ROOM	0	0	0	0	0	11.00
12.00	53.00	ANESTHESIOLOGY	369,459	18,473	0	0	312,857	12.00
13.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	306,873	13.00
14.00	60.00	LABORATORY	503,956	25,198	0	0	165,002	14.00
15.00	65.00	RESPIRATORY THERAPY	0	0	0	0	162,749	15.00
16.00	67.00	OCCUPATIONAL THERAPY	0	0	0	0	12,185	16.00
17.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	97,457	17.00
18.00	74.00	RENAL DIALYSIS	0	0	0	0	74,898	18.00
19.00	90.00	CLINIC	3,250,657	162,533	0	0	987,027	19.00
20.00	91.00	EMERGENCY	1,822,057	91,103	0	0	416,652	20.00
200.00			16,975,065	848,754	0	0	5,380,658	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	707,479		1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	906,357		2.00
3.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	69,198	6,762,461	807,366	2,218,652		3.00
4.00	30.00	ADULTS & PEDIATRICS	392,178	4,727,851	996,217	15,912,589		4.00
5.00	33.00	BURN INTENSIVE CARE UNIT	0	0	0	253,117		5.00
6.00	34.00	SURGICAL INTENSIVE CARE UNIT	0	0	0	274,203		6.00
7.00	34.01	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	627,473		7.00
8.00	34.02	TRAUMA INTENSIVE CARE UNIT	0	0	0	1,005,541		8.00
9.00	34.04	NEONATAL INTENSIVE CARE UNIT	0	0	0	3,399,131		9.00
10.00	50.00	OPERATING ROOM	0	0	0	16,011,061		10.00
11.00	51.00	RECOVERY ROOM	0	0	0	0		11.00
12.00	53.00	ANESTHESIOLOGY	36,169	405,628	92,714	3,904,905		12.00
13.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	5,275,194		13.00
14.00	60.00	LABORATORY	32,281	536,237	0	1,950,807		14.00
15.00	65.00	RESPIRATORY THERAPY	0	0	0	2,797,685		15.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet A-8-2 | Date/Time Prepared: 12/21/2018 2:13 pm

	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		
16.00	67.00	OCCUPATIONAL THERAPY	0	0	0	209,460		16.00
17.00	69.00	ELECTROCARDIOLOGY	0	0	0	1,675,296		17.00
18.00	74.00	RENAL DIALYSIS	0	0	0	1,287,503		18.00
19.00	90.00	CLINIC	258,527	3,509,184	260,260	10,882,115		19.00
20.00	91.00	EMERGENCY	145,577	1,967,634	0	3,639,022		20.00
200.00			933,930	17,908,995	2,156,557	72,937,590		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet B Part I Date/Time Prepared: 12/21/2018 2:13 pm

		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	51,257,328	51,257,328				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	16,057,609		16,057,609			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	129,787,580	411,911	32,027	130,231,518		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	292,163,777	7,667,376	2,546,961	11,687,429	314,065,543	5.00
7.00	00700	OPERATION OF PLANT	29,722,643	18,306,896	775,693	4,713,342	53,518,574	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,787,756	377,420	328	0	3,165,504	8.00
9.00	00900	HOUSEKEEPING	9,145,264	404,311	4,991	2,183,409	11,737,975	9.00
10.00	01000	DIETARY	3,071,142	21,681	823	495,202	3,588,848	10.00
11.00	01100	CAFETERIA	5,489,744	905,851	24,393	745,651	7,165,639	11.00
13.00	01300	NURSING ADMINISTRATION	7,397,167	246,626	229,018	945,184	8,817,995	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	23,864,609	1,427,888	318,895	1,135,725	26,747,117	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,069,223	647,406	1,777	1,096,798	7,815,204	16.00
17.00	01700	SOCIAL SERVICE	46,268	77,895	321	46,642	171,126	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	32,677,398	22,370	2,062	8,619,865	41,321,695	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	3,508,575	0	0	3,351,401	6,859,976	22.00
23.00	02300	ALLIED HEALTH	204,180	2,691	0	59,140	266,011	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	43,893,632	5,801,332	4,039,386	16,700,479	70,434,829	30.00
31.00	03100	INTENSIVE CARE UNIT	8,640,828	603,937	0	2,413,767	11,658,532	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	4,849,237	128,921	270	1,420,559	6,398,987	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	3,245,599	203,135	0	989,206	4,437,940	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	65,280	143,110	2,067	197,340	407,797	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	5,182,894	488,385	391,884	1,590,543	7,653,706	34.02
34.03	02400	NEURO INTENSIVE CARE	2,592,014	102,052	0	729,723	3,423,789	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	3,657,385	260,233	30,681	2,070,998	6,019,297	34.04
43.00	04300	NURSERY	2,288,285	186,170	0	649,799	3,124,254	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	37,295,984	1,490,110	3,994,212	10,814,295	53,594,601	50.00
51.00	05100	RECOVERY ROOM	3,695,998	287,533	2,120	1,066,243	5,051,894	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,907,097	284,884	0	1,098,881	5,290,862	52.00
53.00	05300	ANESTHESIOLOGY	4,382,113	99,361	758,919	2,849,969	8,090,362	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,348,041	2,022,761	203,673	5,647,980	34,222,455	54.00
60.00	06000	LABORATORY	32,617,497	1,656,299	447,809	4,741,597	39,463,202	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	4,851,869	59,380	5,710	296,471	5,213,430	62.00
65.00	06500	RESPIRATORY THERAPY	5,376,929	118,587	299,937	2,154,065	7,949,518	65.00
66.00	06600	PHYSICAL THERAPY	2,534,915	99,253	3,610	631,213	3,268,991	66.00
67.00	06700	OCCUPATIONAL THERAPY	552,831	95,464	0	220,583	868,878	67.00
68.00	06800	SPEECH PATHOLOGY	423,753	49,217	8,391	122,738	604,099	68.00
69.00	06900	ELECTROCARDIOLOGY	6,814,128	457,705	985,818	1,718,168	9,975,819	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,498,175	0	0	0	3,498,175	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,165,284	0	0	0	4,165,284	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	97,166,356	247,228	26,001	6,240,195	103,679,780	73.00
74.00	07400	RENAL DIALYSIS	2,758,176	50,079	19,385	1,156,822	3,984,462	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	97,561,456	4,060,032	713,740	20,856,794	123,192,022	90.00
91.00	09100	EMERGENCY	25,911,465	1,553,429	186,707	8,578,919	36,230,520	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)	1,047,527,484	51,068,919	16,057,609	130,037,135	1,047,144,692	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	671,106	132,991	0	194,383	998,480	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	COUNTYCARE	0	55,418	0	0	55,418	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)	1,048,198,590	51,257,328	16,057,609	130,231,518	1,048,198,590	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet B Part I | Date/Time Prepared: 12/21/2018 2:13 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	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	314,065,543					5.00
7.00	00700	OPERATION OF PLANT	22,895,514	76,414,088				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,354,218	1,159,585	5,679,307			8.00
9.00	00900	HOUSEKEEPING	5,021,564	1,242,205	0	18,001,744		9.00
10.00	01000	DIETARY	1,535,327	66,612	0	16,202	5,206,989	10.00
11.00	01100	CAFETERIA	3,065,496	2,783,137	0	676,932	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,772,382	757,732	0	184,301	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,442,550	4,387,042	0	1,067,044	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,343,383	1,989,089	0	483,799	0	16.00
17.00	01700	SOCIAL SERVICE	73,209	239,326	0	58,210	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	17,677,628	68,728	0	16,717	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	2,934,732	0	0	0	0	22.00
23.00	02300	ALLIED HEALTH	113,801	8,269	0	2,011	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,132,372	17,824,007	1,500,109	4,335,269	3,583,013	30.00
31.00	03100	INTENSIVE CARE UNIT	4,987,578	1,855,535	229,333	451,315	250,961	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	2,737,519	396,098	173,874	96,341	49,458	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,898,573	624,112	234,904	151,801	77,896	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	174,458	439,690	56,551	106,944	34,472	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	3,274,294	1,500,515	259,795	364,965	46,855	34.02
34.03	02400	NEURO INTENSIVE CARE	1,464,714	313,544	21,673	76,262	81,205	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	2,575,085	799,538	206,272	194,469	0	34.04
43.00	04300	NURSERY	1,336,571	571,987	72,421	139,122	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	22,928,038	4,578,212	790,270	1,113,542	0	50.00
51.00	05100	RECOVERY ROOM	2,161,226	883,415	251,571	214,870	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,263,457	875,279	310,686	212,891	0	52.00
53.00	05300	ANESTHESIOLOGY	3,461,097	305,276	40,136	74,251	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,640,537	6,214,729	580,343	1,511,586	0	54.00
60.00	06000	LABORATORY	16,882,555	5,088,813	0	1,237,734	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,230,331	182,438	0	44,374	0	62.00
65.00	06500	RESPIRATORY THERAPY	3,400,844	364,347	0	88,619	0	65.00
66.00	06600	PHYSICAL THERAPY	1,398,491	304,945	45,658	74,171	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	371,710	293,303	0	71,339	0	67.00
68.00	06800	SPEECH PATHOLOGY	258,437	151,216	0	36,780	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,267,705	1,406,253	62,925	342,038	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,496,537	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,781,929	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	44,354,728	759,585	0	184,751	0	73.00
74.00	07400	RENAL DIALYSIS	1,704,573	153,862	0	37,423	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	52,701,919	12,474,042	37,472	3,034,016	330,609	90.00
91.00	09100	EMERGENCY	15,499,598	4,772,755	805,314	1,160,860	752,520	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)	313,614,680	75,835,221	5,679,307	17,860,949	5,206,989	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	427,155	408,600	0	99,382	0	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	COUNTYCARE	23,708	170,267	0	41,413	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)	314,065,543	76,414,088	5,679,307	18,001,744	5,206,989	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet B Part I Date/Time Prepared: 12/21/2018 2:13 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			11.00	13.00	14.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	13,691,204					11.00
13.00	01300	NURSING ADMINISTRATION	260,784	13,793,194				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	291,040	388,473	44,323,266			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	198,432	262,869	0	14,092,776		16.00
17.00	01700	SOCIAL SERVICE	10,700	4,859	0	0	557,430	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,467,156	9,493	891	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	98,407	56,960	880	0	0	22.00
23.00	02300	ALLIED HEALTH	15,879	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,860,446	1,881,610	155,655	1,850,020	168,678	30.00
31.00	03100	INTENSIVE CARE UNIT	328,523	428,178	49,202	252,009	13,757	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	146,858	181,607	55,772	46,516	6,849	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	111,777	144,204	29,513	77,838	10,323	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	98,730	115,291	0	39,004	6,849	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	196,772	219,744	19,364	75,508	10,323	34.02
34.03	02400	NEURO INTENSIVE CARE	87,266	116,354	10,850	59,948	10,323	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	255,215	266,722	9,942	211,362	10,323	34.04
43.00	04300	NURSERY	78,094	104,056	15,498	17,308	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,152,796	1,220,917	5,548,409	1,792,435	0	50.00
51.00	05100	RECOVERY ROOM	147,517	192,190	0	197,360	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	135,904	178,857	16,991	26,863	0	52.00
53.00	05300	ANESTHESIOLOGY	149,837	98,187	54,765	640,803	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,038,438	1,268,062	891,407	1,882,148	0	54.00
60.00	06000	LABORATORY	576,363	645,461	4,261,761	1,358,467	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	82,609	110,265	1,365,605	83,047	0	62.00
65.00	06500	RESPIRATORY THERAPY	278,380	299,089	41,169	89,126	0	65.00
66.00	06600	PHYSICAL THERAPY	96,490	128,792	71,328	76,584	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	41,727	50,985	0	21,973	0	67.00
68.00	06800	SPEECH PATHOLOGY	19,591	26,149	0	18,342	0	68.00
69.00	06900	ELECTROCARDIOLOGY	207,684	229,106	786,984	384,500	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	2,733,832	120,696	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	126,516	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	879,882	1,156,280	24,573,978	1,818,181	0	73.00
74.00	07400	RENAL DIALYSIS	88,773	83,789	3,253	88,716	20,646	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,841,092	3,515,112	3,324,572	2,002,490	196,131	90.00
91.00	09100	EMERGENCY	433,844	409,533	301,645	735,016	103,228	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)	13,677,006	13,793,194	44,323,266	14,092,776	557,430	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	14,198	0	0	0	0	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	COUNTYCARE	0	0	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)	13,691,204	13,793,194	44,323,266	14,092,776	557,430	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet B Part I | Date/Time Prepared: 12/21/2018 2:13 pm

		Cost Center Description	INTERNS & RESIDENTS: SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS: SERVICES-OTHER PRGM COSTS APPRV	ALLIED HEALTH	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			21.00	22.00	23.00	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
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
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	60,562,308					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		9,950,955				22.00
23.00	02300	ALLIED HEALTH			405,971			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,556,605	2,227,477	0	149,510,090	-15,784,082	30.00
31.00	03100	INTENSIVE CARE UNIT	2,134,779	350,764	0	22,990,466	-2,485,543	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	428,477	70,403	0	10,788,759	-498,880	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	622,433	102,272	0	8,523,586	-724,705	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	253,537	41,658	0	1,774,981	-295,195	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	0	0	0	13,621,841	0	34.02
34.03	02400	NEURO INTENSIVE CARE	95,076	15,622	0	5,776,626	-110,698	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	1,140,915	187,463	0	11,876,603	-1,328,378	34.04
43.00	04300	NURSERY	352,416	57,905	0	5,869,632	-410,321	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,128,791	1,664,255	0	104,512,266	-11,793,046	50.00
51.00	05100	RECOVERY ROOM	0	0	0	9,100,043	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	807,514	132,682	0	10,251,986	-940,196	52.00
53.00	05300	ANESTHESIOLOGY	3,953,905	649,664	0	17,518,283	-4,603,569	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,542,973	417,834	0	65,210,512	-2,960,807	54.00
60.00	06000	LABORATORY	1,304,446	214,333	0	71,033,135	-1,518,779	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	9,312,099	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,110,491	182,464	0	13,804,047	-1,292,955	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,465,450	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,719,915	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,114,614	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,620,099	266,198	0	19,549,311	-1,886,297	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	7,849,240	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,073,729	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	129,304	21,246	405,971	177,963,686	-150,550	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	6,165,497	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9,979,204	1,639,677	0	215,268,358	-11,618,881	90.00
91.00	09100	EMERGENCY	10,401,343	1,709,038	0	73,315,214	-12,110,381	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)	60,562,308	9,950,955	405,971	1,045,959,969	-70,513,263	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	0	0	0	1,947,815	0	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	COUNTYCARE	0	0	0	290,806	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	60,562,308	9,950,955	405,971	1,048,198,590	-70,513,263	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet B Part I | Date/Time Prepared: 12/21/2018 2:13 pm

		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
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
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV			22.00
23.00	02300	ALLIED HEALTH			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	133,726,008		30.00
31.00	03100	INTENSIVE CARE UNIT	20,504,923		31.00
33.00	03300	BURN INTENSIVE CARE UNIT	10,289,879		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	7,798,881		34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	1,479,786		34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	13,621,841		34.02
34.03	02400	NEURO INTENSIVE CARE	5,665,928		34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	10,548,225		34.04
43.00	04300	NURSERY	5,459,311		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	92,719,220		50.00
51.00	05100	RECOVERY ROOM	9,100,043		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,311,790		52.00
53.00	05300	ANESTHESIOLOGY	12,914,714		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	62,249,705		54.00
60.00	06000	LABORATORY	69,514,356		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	9,312,099		62.00
65.00	06500	RESPIRATORY THERAPY	12,511,092		65.00
66.00	06600	PHYSICAL THERAPY	5,465,450		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,719,915		67.00
68.00	06800	SPEECH PATHOLOGY	1,114,614		68.00
69.00	06900	ELECTROCARDIOLOGY	17,663,014		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,849,240		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,073,729		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	177,813,136		73.00
74.00	07400	RENAL DIALYSIS	6,165,497		74.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	203,649,477		90.00
91.00	09100	EMERGENCY	61,204,833		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)	975,446,706		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
190.03	19003	SPECIAL FUNDS	1,947,815		190.03
190.04	19004	SENGSTACKE CLINIC	0		190.04
194.00	07950	COUNTYCARE	290,806		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)	977,685,327		202.00

COST ALLOCATION STATISTICS | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet Non-CMS W | Date/Time Prepared: 12/21/2018 2:13 pm

	Cost Center Description	Statistics Code	Statistics Description	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-1	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	5	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	6	MEALS SERVED	10.00
11.00	CAFETERIA	7	HOURS	11.00
13.00	NURSING ADMINISTRATION	9	DIRECT NRSING HRS	13.00
14.00	CENTRAL SERVICES & SUPPLY	10	COSTED REQUIS.	14.00
16.00	MEDICAL RECORDS & LIBRARY	C	GROSS CHAR GES	16.00
17.00	SOCIAL SERVICE	13	TIME SPENT	17.00
21.00	I&R SERVICES-SALARY & FRINGES APPRV	15	ASSIGNED TIME	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	15	ASSIGNED TIME	22.00
23.00	ALLIED HEALTH	23	ASSIGNED TIME	23.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet B Part II Date/Time Prepared: 12/21/2018 2:13 pm

		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	411,911	32,027	443,938	443,938	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	44,019,398	7,667,376	2,546,961	54,233,735	39,826	5.00
7.00	00700	OPERATION OF PLANT	5,034	18,306,896	775,693	19,087,623	16,061	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	377,420	328	377,748	0	8.00
9.00	00900	HOUSEKEEPING	0	404,311	4,991	409,302	7,440	9.00
10.00	01000	DIETARY	0	21,681	823	22,504	1,687	10.00
11.00	01100	CAFETERIA	0	905,851	24,393	930,244	2,541	11.00
13.00	01300	NURSING ADMINISTRATION	0	246,626	229,018	475,644	3,221	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	194,452	1,427,888	318,895	1,941,235	3,870	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	647,406	1,777	649,183	3,737	16.00
17.00	01700	SOCIAL SERVICE	0	77,895	321	78,216	159	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	22,370	2,062	24,432	29,373	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	11,420	22.00
23.00	02300	ALLIED HEALTH	0	2,691	0	2,691	202	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	5,801,332	4,039,386	9,840,718	56,909	30.00
31.00	03100	INTENSIVE CARE UNIT	0	603,937	0	603,937	8,225	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	128,921	270	129,191	4,841	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	203,135	0	203,135	3,371	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	143,110	2,067	145,177	672	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	0	488,385	391,884	880,269	5,420	34.02
34.03	02400	NEURO INTENSIVE CARE	0	102,052	0	102,052	2,487	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	0	260,233	30,681	290,914	7,057	34.04
43.00	04300	NURSERY	0	186,170	0	186,170	2,214	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,131	1,490,110	3,994,212	5,485,453	36,851	50.00
51.00	05100	RECOVERY ROOM	0	287,533	2,120	289,653	3,633	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	284,884	0	284,884	3,745	52.00
53.00	05300	ANESTHESIOLOGY	0	99,361	758,919	858,280	9,712	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	360,000	2,022,761	203,673	2,586,434	19,246	54.00
60.00	06000	LABORATORY	0	1,656,299	447,809	2,104,108	16,158	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	59,380	5,710	65,090	1,010	62.00
65.00	06500	RESPIRATORY THERAPY	844,110	118,587	299,937	1,262,634	7,340	65.00
66.00	06600	PHYSICAL THERAPY	0	99,253	3,610	102,863	2,151	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	95,464	0	95,464	752	67.00
68.00	06800	SPEECH PATHOLOGY	0	49,217	8,391	57,608	418	68.00
69.00	06900	ELECTROCARDIOLOGY	0	457,705	985,818	1,443,523	5,855	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,000,843	247,228	26,001	1,274,072	21,264	73.00
74.00	07400	RENAL DIALYSIS	0	50,079	19,385	69,464	3,942	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,009,722	4,060,032	713,740	5,783,494	71,232	90.00
91.00	09100	EMERGENCY	0	1,553,429	186,707	1,740,136	29,234	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)	47,434,690	51,068,919	16,057,609	114,561,218	443,276	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	0	132,991	0	132,991	662	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	COUNTYCARE	0	55,418	0	55,418	0	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)	47,434,690	51,257,328	16,057,609	114,749,627	443,938	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet B Part II Date/Time Prepared: 12/21/2018 2:13 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	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	54,273,561					5.00
7.00	00700	OPERATION OF PLANT	3,956,575	23,060,259				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	234,023	349,940	961,711			8.00
9.00	00900	HOUSEKEEPING	867,777	374,873	0	1,659,392		9.00
10.00	01000	DIETARY	265,320	20,102	0	1,493	311,106	10.00
11.00	01100	CAFETERIA	529,749	839,896	0	62,399	0	11.00
13.00	01300	NURSING ADMINISTRATION	651,906	228,669	0	16,989	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,977,388	1,323,923	0	98,360	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	577,770	600,268	0	44,596	0	16.00
17.00	01700	SOCIAL SERVICE	12,651	72,224	0	5,366	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	3,054,872	20,741	0	1,541	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	507,151	0	0	0	0	22.00
23.00	02300	ALLIED HEALTH	19,666	2,495	0	185	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,207,176	5,378,930	254,022	399,625	214,078	30.00
31.00	03100	INTENSIVE CARE UNIT	861,904	559,964	38,834	41,602	14,994	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	473,071	119,535	29,443	8,881	2,955	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	328,092	188,345	39,778	13,993	4,654	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	30,148	132,690	9,576	9,858	2,060	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	565,831	452,826	43,993	33,642	2,799	34.02
34.03	02400	NEURO INTENSIVE CARE	253,117	94,622	3,670	7,030	4,852	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	445,001	241,285	34,929	17,926	0	34.04
43.00	04300	NURSERY	230,973	172,614	12,264	12,824	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,962,195	1,381,614	133,821	102,646	0	50.00
51.00	05100	RECOVERY ROOM	373,481	266,597	42,600	19,807	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	391,148	264,142	52,610	19,624	0	52.00
53.00	05300	ANESTHESIOLOGY	598,112	92,126	6,796	6,844	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,530,032	1,875,482	98,273	139,337	0	54.00
60.00	06000	LABORATORY	2,917,475	1,535,703	0	114,094	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	385,424	55,056	0	4,090	0	62.00
65.00	06500	RESPIRATORY THERAPY	587,700	109,953	0	8,169	0	65.00
66.00	06600	PHYSICAL THERAPY	241,673	92,026	7,732	6,837	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	64,235	88,513	0	6,576	0	67.00
68.00	06800	SPEECH PATHOLOGY	44,660	45,634	0	3,390	0	68.00
69.00	06900	ELECTROCARDIOLOGY	737,502	424,379	10,656	31,529	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	258,617	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	307,935	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,664,942	229,228	0	17,030	0	73.00
74.00	07400	RENAL DIALYSIS	294,567	46,432	0	3,450	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9,107,302	3,764,419	6,345	279,674	19,753	90.00
91.00	09100	EMERGENCY	2,678,486	1,440,323	136,369	107,007	44,961	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)	54,195,647	22,885,569	961,711	1,646,414	311,106	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	73,817	123,307	0	9,161	0	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	COUNTYCARE	4,097	51,383	0	3,817	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)	54,273,561	23,060,259	961,711	1,659,392	311,106	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet B Part II | Date/Time Prepared: 12/21/2018 2:13 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			11.00	13.00	14.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	2,364,829					11.00
13.00	01300	NURSING ADMINISTRATION	45,044	1,421,473				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	50,270	40,035	5,435,081			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	34,274	27,090	0	1,936,918		16.00
17.00	01700	SOCIAL SERVICE	1,848	501	0	0	170,965	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	253,416	978	109	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	16,997	5,870	108	0	0	22.00
23.00	02300	ALLIED HEALTH	2,743	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	321,347	193,912	19,087	254,365	51,734	30.00
31.00	03100	INTENSIVE CARE UNIT	56,745	44,126	6,033	34,649	4,219	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	25,366	18,716	6,839	6,396	2,101	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	19,307	14,861	3,619	10,702	3,166	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	17,053	11,881	0	5,363	2,101	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	33,988	22,646	2,374	10,382	3,166	34.02
34.03	02400	NEURO INTENSIVE CARE	15,073	11,991	1,330	8,242	3,166	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	44,082	27,487	1,219	29,061	3,166	34.04
43.00	04300	NURSERY	13,489	10,724	1,900	2,380	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	199,118	125,823	680,362	246,447	0	50.00
51.00	05100	RECOVERY ROOM	25,480	19,806	0	27,136	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	23,474	18,432	2,083	3,693	0	52.00
53.00	05300	ANESTHESIOLOGY	25,881	10,119	6,715	88,106	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	179,365	130,682	109,307	258,782	0	54.00
60.00	06000	LABORATORY	99,553	66,519	522,589	186,780	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	14,269	11,363	167,454	11,418	0	62.00
65.00	06500	RESPIRATORY THERAPY	48,084	30,823	5,048	12,254	0	65.00
66.00	06600	PHYSICAL THERAPY	16,666	13,273	8,746	10,530	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,207	5,254	0	3,021	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,384	2,695	0	2,522	0	68.00
69.00	06900	ELECTROCARDIOLOGY	35,872	23,611	96,502	52,866	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	335,230	16,595	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	17,395	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	151,979	119,162	3,013,370	249,987	0	73.00
74.00	07400	RENAL DIALYSIS	15,333	8,635	399	12,198	6,332	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	490,734	362,253	407,669	274,588	60,154	90.00
91.00	09100	EMERGENCY	74,936	42,205	36,989	101,060	31,660	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)	2,362,377	1,421,473	5,435,081	1,936,918	170,965	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	2,452	0	0	0	0	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	COUNTYCARE	0	0	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)	2,364,829	1,421,473	5,435,081	1,936,918	170,965	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet B Part II | Date/Time Prepared: 12/21/2018 2:13 pm

		Cost Center Description	INTERNS & RESIDENTS: SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS: SERVICES-OTHER PRGM COSTS APPRV	ALLIED HEALTH	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			21.00	22.00	23.00	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
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
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	3,385,462					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		541,546				22.00
23.00	02300	ALLIED HEALTH			27,982			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				22,191,903	0	30.00
31.00	03100	INTENSIVE CARE UNIT				2,275,232	0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT				827,335	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT				833,023	0	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT				366,579	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT				2,057,336	0	34.02
34.03	02400	NEURO INTENSIVE CARE				507,632	0	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT				1,142,127	0	34.04
43.00	04300	NURSERY				645,552	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM				12,354,330	0	50.00
51.00	05100	RECOVERY ROOM				1,068,193	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM				1,063,835	0	52.00
53.00	05300	ANESTHESIOLOGY				1,702,691	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				7,926,940	0	54.00
60.00	06000	LABORATORY				7,562,979	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL				715,174	0	62.00
65.00	06500	RESPIRATORY THERAPY				2,072,005	0	65.00
66.00	06600	PHYSICAL THERAPY				502,497	0	66.00
67.00	06700	OCCUPATIONAL THERAPY				271,022	0	67.00
68.00	06800	SPEECH PATHOLOGY				160,311	0	68.00
69.00	06900	ELECTROCARDIOLOGY				2,862,295	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				610,442	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				325,330	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				12,741,034	0	73.00
74.00	07400	RENAL DIALYSIS				460,752	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC				20,627,617	0	90.00
91.00	09100	EMERGENCY				6,463,366	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)	0	0	0	110,337,532	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				0	0	190.00
190.03	19003	SPECIAL FUNDS				342,390	0	190.03
190.04	19004	SENGSTACKE CLINIC				0	0	190.04
194.00	07950	COUNTYCARE				114,715	0	194.00
200.00		Cross Foot Adjustments	3,385,462	541,546	27,982	3,954,990	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,385,462	541,546	27,982	114,749,627	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet B Part II | Date/Time Prepared: 12/21/2018 2:13 pm

		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
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
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	ALLIED HEALTH	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	22,191,903	30.00
31.00	03100	INTENSIVE CARE UNIT	2,275,232	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	827,335	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	833,023	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	366,579	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	2,057,336	34.02
34.03	02400	NEURO INTENSIVE CARE	507,632	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	1,142,127	34.04
43.00	04300	NURSERY	645,552	43.00
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	12,354,330	50.00
51.00	05100	RECOVERY ROOM	1,068,193	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,063,835	52.00
53.00	05300	ANESTHESIOLOGY	1,702,691	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,926,940	54.00
60.00	06000	LABORATORY	7,562,979	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	715,174	62.00
65.00	06500	RESPIRATORY THERAPY	2,072,005	65.00
66.00	06600	PHYSICAL THERAPY	502,497	66.00
67.00	06700	OCCUPATIONAL THERAPY	271,022	67.00
68.00	06800	SPEECH PATHOLOGY	160,311	68.00
69.00	06900	ELECTROCARDIOLOGY	2,862,295	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	610,442	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	325,330	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,741,034	73.00
74.00	07400	RENAL DIALYSIS	460,752	74.00
		OUTPATIENT SERVICE COST CENTERS	
90.00	09000	CLINIC	20,627,617	90.00
91.00	09100	EMERGENCY	6,463,366	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)	110,337,532	118.00
		NONREIMBURSABLE COST CENTERS	
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
190.03	19003	SPECIAL FUNDS	342,390	190.03
190.04	19004	SENGSTACKE CLINIC	0	190.04
194.00	07950	COUNTYCARE	114,715	194.00
200.00		Cross Foot Adjustments	3,954,990	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	114,749,627	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet B-1 | Date/Time Prepared: 12/21/2018 2:13 pm

		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	2,380,745					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		6,361,062				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	19,132	12,687	449,623,315			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	356,126	1,008,953	40,350,736	-314,065,543	734,133,047	5.00
7.00	00700	OPERATION OF PLANT	850,299	307,283	16,272,766	0	53,518,574	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,530	130	0	0	3,165,504	8.00
9.00	00900	HOUSEKEEPING	18,779	1,977	7,538,197	0	11,737,975	9.00
10.00	01000	DIETARY	1,007	326	1,709,681	0	3,588,848	10.00
11.00	01100	CAFETERIA	42,074	9,663	2,574,354	0	7,165,639	11.00
13.00	01300	NURSING ADMINISTRATION	11,455	90,723	3,263,238	0	8,817,995	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	66,321	126,327	3,921,081	0	26,747,117	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	30,070	704	3,786,686	0	7,815,204	16.00
17.00	01700	SOCIAL SERVICE	3,618	127	161,031	0	171,126	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,039	817	29,759,999	0	41,321,695	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	11,570,679	0	6,859,976	22.00
23.00	02300	ALLIED HEALTH	125	0	204,180	0	266,011	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	269,454	1,600,164	57,658,242	0	70,434,829	30.00
31.00	03100	INTENSIVE CARE UNIT	28,051	0	8,333,507	0	11,658,532	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	5,988	107	4,904,467	0	6,398,987	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	9,435	0	3,415,225	0	4,437,940	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	6,647	819	681,315	0	407,797	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	22,684	155,241	5,491,333	0	7,653,706	34.02
34.03	02400	NEURO INTENSIVE CARE	4,740	0	2,519,360	0	3,423,789	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	12,087	12,154	7,150,100	0	6,019,297	34.04
43.00	04300	NURSERY	8,647	0	2,243,425	0	3,124,254	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	69,211	1,582,267	37,336,247	0	53,594,601	50.00
51.00	05100	RECOVERY ROOM	13,355	840	3,681,192	0	5,051,894	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,232	0	3,793,875	0	5,290,862	52.00
53.00	05300	ANESTHESIOLOGY	4,615	300,638	9,839,491	0	8,090,362	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	93,951	80,683	19,499,596	0	34,222,455	54.00
60.00	06000	LABORATORY	76,930	177,395	16,370,319	0	39,463,202	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,758	2,262	1,023,563	0	5,213,430	62.00
65.00	06500	RESPIRATORY THERAPY	5,508	118,817	7,436,889	0	7,949,518	65.00
66.00	06600	PHYSICAL THERAPY	4,610	1,430	2,179,258	0	3,268,991	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,434	0	761,562	0	868,878	67.00
68.00	06800	SPEECH PATHOLOGY	2,286	3,324	423,753	0	604,099	68.00
69.00	06900	ELECTROCARDIOLOGY	21,259	390,522	5,931,958	0	9,975,819	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	3,498,175	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	4,165,284	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,483	10,300	21,544,214	0	103,679,780	73.00
74.00	07400	RENAL DIALYSIS	2,326	7,679	3,993,916	0	3,984,462	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	188,576	282,741	72,008,139	0	123,192,022	90.00
91.00	09100	EMERGENCY	72,152	73,962	29,618,635	0	36,230,520	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)	2,371,994	6,361,062	448,952,209	-314,065,543	733,079,149	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	6,177	0	671,106	0	998,480	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	COUNTYCARE	2,574	0	0	0	55,418	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)	51,257,328	16,057,609	130,231,518		314,065,543	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.529953	2.524360	0.289646		0.427805	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			443,938		54,273,561	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000987		0.073929	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: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet B-1 | Date/Time Prepared: 12/21/2018 2:13 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	1,155,188					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,530	2,232,635				8.00
9.00	00900	HOUSEKEEPING	18,779	0	1,118,879			9.00
10.00	01000	DIETARY	1,007	0	1,007	214,038		10.00
11.00	01100	CAFETERIA	42,074	0	42,074	0	8,067,613	11.00
13.00	01300	NURSING ADMINISTRATION	11,455	0	11,455	0	153,668	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	66,321	0	66,321	0	171,497	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	30,070	0	30,070	0	116,927	16.00
17.00	01700	SOCIAL SERVICE	3,618	0	3,618	0	6,305	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,039	0	1,039	0	864,529	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	57,987	22.00
23.00	02300	ALLIED HEALTH	125	0	125	0	9,357	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	269,454	589,719	269,454	147,283	1,096,277	30.00
31.00	03100	INTENSIVE CARE UNIT	28,051	90,155	28,051	10,316	193,584	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	5,988	68,353	5,988	2,033	86,537	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	9,435	92,345	9,435	3,202	65,865	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	6,647	22,231	6,647	1,417	58,177	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	22,684	102,130	22,684	1,926	115,949	34.02
34.03	02400	NEURO INTENSIVE CARE	4,740	8,520	4,740	3,338	51,422	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	12,087	81,089	12,087	0	150,387	34.04
43.00	04300	NURSERY	8,647	28,470	8,647	0	46,017	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	69,211	310,669	69,211	0	679,291	50.00
51.00	05100	RECOVERY ROOM	13,355	98,897	13,355	0	86,925	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,232	122,136	13,232	0	80,082	52.00
53.00	05300	ANESTHESIOLOGY	4,615	15,778	4,615	0	88,292	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	93,951	228,143	93,951	0	611,905	54.00
60.00	06000	LABORATORY	76,930	0	76,930	0	339,625	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,758	0	2,758	0	48,678	62.00
65.00	06500	RESPIRATORY THERAPY	5,508	0	5,508	0	164,037	65.00
66.00	06600	PHYSICAL THERAPY	4,610	17,949	4,610	0	56,857	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,434	0	4,434	0	24,588	67.00
68.00	06800	SPEECH PATHOLOGY	2,286	0	2,286	0	11,544	68.00
69.00	06900	ELECTROCARDIOLOGY	21,259	24,737	21,259	0	122,379	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,483	0	11,483	0	518,475	73.00
74.00	07400	RENAL DIALYSIS	2,326	0	2,326	0	52,310	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	188,576	14,731	188,576	13,590	1,674,129	90.00
91.00	09100	EMERGENCY	72,152	316,583	72,152	30,933	255,645	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)	1,146,437	2,232,635	1,110,128	214,038	8,059,247	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	6,177	0	6,177	0	8,366	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	COUNTYCARE	2,574	0	2,574	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)	76,414,088	5,679,307	18,001,744	5,206,989	13,691,204	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	66.148617	2.543769	16.089089	24.327404	1.697058	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	23,060,259	961,711	1,659,392	311,106	2,364,829	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	19.962343	0.430752	1.483084	1.453508	0.293126	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: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet B-1 | Date/Time Prepared: 12/21/2018 2:13 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	
			13.00	14.00	16.00	17.00	21.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	6,089,200					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	171,497	124,246,575				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	116,047	0	1,336,264,952			16.00
17.00	01700	SOCIAL SERVICE	2,145	0	0	56,160		17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	4,191	2,498	0	0	47,774	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	25,146	2,467	0	0		22.00
23.00	02300	ALLIED HEALTH	0	0	0	0		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	830,663	436,332	175,423,854	16,994	10,694	30.00
31.00	03100	INTENSIVE CARE UNIT	189,025	137,924	23,896,157	1,386	1,684	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	80,173	156,340	4,410,749	690	338	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	63,661	82,732	7,380,806	1,040	491	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	50,897	0	3,698,506	690	200	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	97,009	54,281	7,159,909	1,040	0	34.02
34.03	02400	NEURO INTENSIVE CARE	51,366	30,415	5,684,456	1,040	75	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	117,748	27,869	20,041,902	1,040	900	34.04
43.00	04300	NURSERY	45,937	43,443	1,641,235	0	278	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	538,991	15,553,263	169,963,448	0	7,990	50.00
51.00	05100	RECOVERY ROOM	84,845	0	18,714,165	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	78,959	47,629	2,547,231	0	637	52.00
53.00	05300	ANESTHESIOLOGY	43,346	153,516	60,762,623	0	3,119	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	559,804	2,498,785	178,470,306	0	2,006	54.00
60.00	06000	LABORATORY	284,948	11,946,540	128,813,494	0	1,029	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	48,678	3,828,055	7,874,753	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	132,037	115,405	8,451,197	0	876	65.00
66.00	06600	PHYSICAL THERAPY	56,857	199,947	7,261,908	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	22,508	0	2,083,565	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	11,544	0	1,739,211	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	101,142	2,206,067	36,459,312	0	1,278	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,663,459	11,444,679	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	11,996,622	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	510,456	68,885,505	172,404,824	0	102	73.00
74.00	07400	RENAL DIALYSIS	36,990	9,118	8,412,282	2,080	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,551,796	9,319,417	189,831,536	19,760	7,872	90.00
91.00	09100	EMERGENCY	180,794	845,568	69,696,222	10,400	8,205	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)	6,089,200	124,246,575	1,336,264,952	56,160	47,774	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.03	19003	SPECIAL FUNDS	0	0	0	0	0	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	COUNTYCARE	0	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)	13,793,194	44,323,266	14,092,776	557,430	60,562,308	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.265190	0.356736	0.010546	9.925748	1,267.683426	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,421,473	5,435,081	1,936,918	170,965	3,385,462	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.233442	0.043744	0.001450	3.044249	70.864110	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: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet B-1 | Date/Time Prepared: 12/21/2018 2:13 pm

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	ALLIED HEALTH (ASSIGNED TIME)		
			22.00	23.00		
		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
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
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	47,774			22.00
23.00	02300	ALLIED HEALTH		10,000		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	10,694	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,684	0		31.00
33.00	03300	BURN INTENSIVE CARE UNIT	338	0		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	491	0		34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	200	0		34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	0	0		34.02
34.03	02400	NEURO INTENSIVE CARE	75	0		34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	900	0		34.04
43.00	04300	NURSERY	278	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	7,990	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	637	0		52.00
53.00	05300	ANESTHESIOLOGY	3,119	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,006	0		54.00
60.00	06000	LABORATORY	1,029	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	876	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	1,278	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	102	10,000		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	7,872	0		90.00
91.00	09100	EMERGENCY	8,205	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)	47,774	10,000		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.03	19003	SPECIAL FUNDS	0	0		190.03
190.04	19004	SENGSTACKE CLINIC	0	0		190.04
194.00	07950	COUNTYCARE	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)	9,950,955	405,971		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	208.292272	40.597100		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	541,546	27,982		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	11.335580	2.798200		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet C Part I Date/Time Prepared: 12/21/2018 2:13 pm

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		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	133,726,008		133,726,008	996,217	134,722,225	30.00
31.00	03100	INTENSIVE CARE UNIT	20,504,923		20,504,923	0	20,504,923	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	10,289,879		10,289,879	0	10,289,879	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	7,798,881		7,798,881	0	7,798,881	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	1,479,786		1,479,786	0	1,479,786	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	13,621,841		13,621,841	0	13,621,841	34.02
34.03	02400	NEURO INTENSIVE CARE	5,665,928		5,665,928	0	5,665,928	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	10,548,225		10,548,225	0	10,548,225	34.04
43.00	04300	NURSERY	5,459,311		5,459,311	0	5,459,311	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	92,719,220		92,719,220	0	92,719,220	50.00
51.00	05100	RECOVERY ROOM	9,100,043		9,100,043	0	9,100,043	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,311,790		9,311,790	0	9,311,790	52.00
53.00	05300	ANESTHESIOLOGY	12,914,714		12,914,714	92,714	13,007,428	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	62,249,705		62,249,705	0	62,249,705	54.00
60.00	06000	LABORATORY	69,514,356		69,514,356	0	69,514,356	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	9,312,099		9,312,099	0	9,312,099	62.00
65.00	06500	RESPIRATORY THERAPY	12,511,092	0	12,511,092	0	12,511,092	65.00
66.00	06600	PHYSICAL THERAPY	5,465,450	0	5,465,450	0	5,465,450	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,719,915	0	1,719,915	0	1,719,915	67.00
68.00	06800	SPEECH PATHOLOGY	1,114,614	0	1,114,614	0	1,114,614	68.00
69.00	06900	ELECTROCARDIOLOGY	17,663,014		17,663,014	0	17,663,014	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,849,240		7,849,240	0	7,849,240	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,073,729		6,073,729	0	6,073,729	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	177,813,136		177,813,136	0	177,813,136	73.00
74.00	07400	RENAL DIALYSIS	6,165,497		6,165,497	0	6,165,497	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	203,649,477		203,649,477	260,260	203,909,737	90.00
91.00	09100	EMERGENCY	61,204,833		61,204,833	0	61,204,833	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	32,178,472		32,178,472		32,178,472	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	1,007,625,178	0	1,007,625,178	1,349,191	1,008,974,369	200.00
201.00		Less Observation Beds	32,178,472		32,178,472		32,178,472	201.00
202.00		Total (see instructions)	975,446,706	0	975,446,706	1,349,191	976,795,897	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet C Part I Date/Time Prepared: 12/21/2018 2:13 pm

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	127,672,793		127,672,793			30.00
31.00	03100	INTENSIVE CARE UNIT	23,896,157		23,896,157			31.00
33.00	03300	BURN INTENSIVE CARE UNIT	4,410,749		4,410,749			33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	7,380,806		7,380,806			34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	3,698,506		3,698,506			34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	7,159,909		7,159,909			34.02
34.03	02400	NEURO INTENSIVE CARE	5,684,456		5,684,456			34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	20,041,902		20,041,902			34.04
43.00	04300	NURSERY	1,641,235		1,641,235			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	87,813,422	82,150,026	169,963,448	0.545524	0.000000	50.00
51.00	05100	RECOVERY ROOM	5,005,636	13,708,529	18,714,165	0.486265	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,449,884	97,347	2,547,231	3.655652	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	36,369,411	24,393,212	60,762,623	0.212544	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	41,071,997	137,398,309	178,470,306	0.348796	0.000000	54.00
60.00	06000	LABORATORY	39,505,624	89,307,870	128,813,494	0.539651	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	5,064,654	2,810,099	7,874,753	1.182526	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	5,279,561	3,171,636	8,451,197	1.480393	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,198,748	4,063,160	7,261,908	0.752619	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,415,747	667,818	2,083,565	0.825467	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	654,382	1,084,829	1,739,211	0.640873	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	18,259,852	18,199,460	36,459,312	0.484458	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,009,760	4,434,919	11,444,679	0.685842	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,188,011	2,808,611	11,996,622	0.506287	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	70,776,785	101,628,039	172,404,824	1.031370	0.000000	73.00
74.00	07400	RENAL DIALYSIS	3,116,758	5,295,524	8,412,282	0.732916	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,509,304	188,322,232	189,831,536	1.072791	0.000000	90.00
91.00	09100	EMERGENCY	8,277,651	61,418,571	69,696,222	0.878166	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	18,205,865	29,545,196	47,751,061	0.673880	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	565,759,565	770,505,387	1,336,264,952			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	565,759,565	770,505,387	1,336,264,952			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet C Part I Date/Time Prepared: 12/21/2018 2:13 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio
			11.00
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	
31.00	03100	INTENSIVE CARE UNIT	
33.00	03300	BURN INTENSIVE CARE UNIT	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	
34.02	02180	TRAUMA INTENSIVE CARE UNIT	
34.03	02400	NEURO INTENSIVE CARE	
34.04	02060	NEONATAL INTENSIVE CARE UNIT	
43.00	04300	NURSERY	
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	0.545524
51.00	05100	RECOVERY ROOM	0.486265
52.00	05200	DELIVERY ROOM & LABOR ROOM	3.655652
53.00	05300	ANESTHESIOLOGY	0.214070
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.348796
60.00	06000	LABORATORY	0.539651
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1.182526
65.00	06500	RESPIRATORY THERAPY	1.480393
66.00	06600	PHYSICAL THERAPY	0.752619
67.00	06700	OCCUPATIONAL THERAPY	0.825467
68.00	06800	SPEECH PATHOLOGY	0.640873
69.00	06900	ELECTROCARDIOLOGY	0.484458
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.685842
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.506287
73.00	07300	DRUGS CHARGED TO PATIENTS	1.031370
74.00	07400	RENAL DIALYSIS	0.732916
		OUTPATIENT SERVICE COST CENTERS	
90.00	09000	CLINIC	1.074162
91.00	09100	EMERGENCY	0.878166
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.673880
		SPECIAL PURPOSE COST CENTERS	
113.00	11300	INTEREST EXPENSE	
200.00		Subtotal (see instructions)	
201.00		Less Observation Beds	
202.00		Total (see instructions)	

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet C Part I Date/Time Prepared: 12/21/2018 2:13 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	133,726,008		133,726,008	996,217	134,722,225	30.00
31.00	03100	INTENSIVE CARE UNIT	20,504,923		20,504,923	0	20,504,923	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	10,289,879		10,289,879	0	10,289,879	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	7,798,881		7,798,881	0	7,798,881	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	1,479,786		1,479,786	0	1,479,786	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	13,621,841		13,621,841	0	13,621,841	34.02
34.03	02400	NEURO INTENSIVE CARE	5,665,928		5,665,928	0	5,665,928	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	10,548,225		10,548,225	0	10,548,225	34.04
43.00	04300	NURSERY	5,459,311		5,459,311	0	5,459,311	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	92,719,220		92,719,220	0	92,719,220	50.00
51.00	05100	RECOVERY ROOM	9,100,043		9,100,043	0	9,100,043	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,311,790		9,311,790	0	9,311,790	52.00
53.00	05300	ANESTHESIOLOGY	12,914,714		12,914,714	92,714	13,007,428	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	62,249,705		62,249,705	0	62,249,705	54.00
60.00	06000	LABORATORY	69,514,356		69,514,356	0	69,514,356	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	9,312,099		9,312,099	0	9,312,099	62.00
65.00	06500	RESPIRATORY THERAPY	12,511,092	0	12,511,092	0	12,511,092	65.00
66.00	06600	PHYSICAL THERAPY	5,465,450	0	5,465,450	0	5,465,450	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,719,915	0	1,719,915	0	1,719,915	67.00
68.00	06800	SPEECH PATHOLOGY	1,114,614	0	1,114,614	0	1,114,614	68.00
69.00	06900	ELECTROCARDIOLOGY	17,663,014		17,663,014	0	17,663,014	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,849,240		7,849,240	0	7,849,240	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,073,729		6,073,729	0	6,073,729	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	177,813,136		177,813,136	0	177,813,136	73.00
74.00	07400	RENAL DIALYSIS	6,165,497		6,165,497	0	6,165,497	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	203,649,477		203,649,477	260,260	203,909,737	90.00
91.00	09100	EMERGENCY	61,204,833		61,204,833	0	61,204,833	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	32,178,472		32,178,472		32,178,472	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	1,007,625,178	0	1,007,625,178	1,349,191	1,008,974,369	200.00
201.00		Less Observation Beds	32,178,472		32,178,472		32,178,472	201.00
202.00		Total (see instructions)	975,446,706	0	975,446,706	1,349,191	976,795,897	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet C Part I Date/Time Prepared: 12/21/2018 2:13 pm

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	127,672,793		127,672,793			30.00
31.00	03100	INTENSIVE CARE UNIT	23,896,157		23,896,157			31.00
33.00	03300	BURN INTENSIVE CARE UNIT	4,410,749		4,410,749			33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	7,380,806		7,380,806			34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	3,698,506		3,698,506			34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	7,159,909		7,159,909			34.02
34.03	02400	NEURO INTENSIVE CARE	5,684,456		5,684,456			34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	20,041,902		20,041,902			34.04
43.00	04300	NURSERY	1,641,235		1,641,235			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	87,813,422	82,150,026	169,963,448	0.545524	0.000000	50.00
51.00	05100	RECOVERY ROOM	5,005,636	13,708,529	18,714,165	0.486265	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,449,884	97,347	2,547,231	3.655652	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	36,369,411	24,393,212	60,762,623	0.212544	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	41,071,997	137,398,309	178,470,306	0.348796	0.000000	54.00
60.00	06000	LABORATORY	39,505,624	89,307,870	128,813,494	0.539651	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	5,064,654	2,810,099	7,874,753	1.182526	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	5,279,561	3,171,636	8,451,197	1.480393	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,198,748	4,063,160	7,261,908	0.752619	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,415,747	667,818	2,083,565	0.825467	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	654,382	1,084,829	1,739,211	0.640873	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	18,259,852	18,199,460	36,459,312	0.484458	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,009,760	4,434,919	11,444,679	0.685842	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,188,011	2,808,611	11,996,622	0.506287	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	70,776,785	101,628,039	172,404,824	1.031370	0.000000	73.00
74.00	07400	RENAL DIALYSIS	3,116,758	5,295,524	8,412,282	0.732916	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,509,304	188,322,232	189,831,536	1.072791	0.000000	90.00
91.00	09100	EMERGENCY	8,277,651	61,418,571	69,696,222	0.878166	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	18,205,865	29,545,196	47,751,061	0.673880	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	565,759,565	770,505,387	1,336,264,952			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	565,759,565	770,505,387	1,336,264,952			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet C Part I Date/Time Prepared: 12/21/2018 2:13 pm

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
33.00	03300	BURN INTENSIVE CARE UNIT			33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT			34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT			34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT			34.02
34.03	02400	NEURO INTENSIVE CARE			34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT			34.04
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
		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: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet D Part I Date/Time Prepared: 12/21/2018 2:13 pm

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	22,191,903	0	22,191,903	77,400	286.72	30.00
31.00	INTENSIVE CARE UNIT	2,275,232		2,275,232	8,163	278.72	31.00
33.00	BURN INTENSIVE CARE UNIT	827,335		827,335	1,432	577.75	33.00
34.00	SURGICAL INTENSIVE CARE UNIT	833,023		833,023	2,665	312.58	34.00
34.01	PEDIATRIC INTENSIVE CARE UNIT	366,579		366,579	1,251	293.03	34.01
34.02	TRAUMA INTENSIVE CARE UNIT	2,057,336		2,057,336	2,033	1,011.97	34.02
34.03	NEURO INTENSIVE CARE	507,632		507,632	2,024	250.81	34.03
34.04	NEONATAL INTENSIVE CARE UNIT	1,142,127		1,142,127	7,036	162.33	34.04
43.00	NURSERY	645,552		645,552	1,763	366.17	43.00
200.00	Total (lines 30 through 199)	30,846,719		30,846,719	103,767		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	8,286	2,375,762				30.00
31.00	INTENSIVE CARE UNIT	1,482	413,063				31.00
33.00	BURN INTENSIVE CARE UNIT	249	143,860				33.00
34.00	SURGICAL INTENSIVE CARE UNIT	401	125,345				34.00
34.01	PEDIATRIC INTENSIVE CARE UNIT	0	0				34.01
34.02	TRAUMA INTENSIVE CARE UNIT	181	183,167				34.02
34.03	NEURO INTENSIVE CARE	198	49,660				34.03
34.04	NEONATAL INTENSIVE CARE UNIT	0	0				34.04
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	10,797	3,290,857				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet D Part II Date/Time Prepared: 12/21/2018 2:13 pm

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	12,354,330	169,963,448	0.072688	9,179,383	667,231	50.00
51.00	05100	RECOVERY ROOM	1,068,193	18,714,165	0.057079	431,018	24,602	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,063,835	2,547,231	0.417644	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,702,691	60,762,623	0.028022	3,349,869	93,870	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,926,940	178,470,306	0.044416	4,722,998	209,777	54.00
60.00	06000	LABORATORY	7,562,979	128,813,494	0.058713	5,436,365	319,185	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	715,174	7,874,753	0.090819	535,629	48,645	62.00
65.00	06500	RESPIRATORY THERAPY	2,072,005	8,451,197	0.245173	1,372,128	336,409	65.00
66.00	06600	PHYSICAL THERAPY	502,497	7,261,908	0.069196	516,616	35,748	66.00
67.00	06700	OCCUPATIONAL THERAPY	271,022	2,083,565	0.130076	215,730	28,061	67.00
68.00	06800	SPEECH PATHOLOGY	160,311	1,739,211	0.092175	90,369	8,330	68.00
69.00	06900	ELECTROCARDIOLOGY	2,862,295	36,459,312	0.078507	2,234,412	175,417	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	610,442	11,444,679	0.053338	562,776	30,017	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	325,330	11,996,622	0.027118	767,817	20,822	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,741,034	172,404,824	0.073902	7,815,048	577,548	73.00
74.00	07400	RENAL DIALYSIS	460,752	8,412,282	0.054771	735,606	40,290	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	20,627,617	189,831,536	0.108663	657,523	71,448	90.00
91.00	09100	EMERGENCY	6,463,366	69,696,222	0.092736	1,169,527	108,457	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5,300,534	47,751,061	0.111003	2,282,514	253,366	92.00
200.00		Total (lines 50 through 199)	84,791,347	1,134,678,439		42,075,328	3,049,223	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet D Part III Date/Time Prepared: 12/21/2018 2:13 pm

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
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	0	0	0	0	0	34.02
34.03	02400	NEURO INTENSIVE CARE	0	0	0	0	0	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	34.04
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	77,400	0.00	8,286	30.00
31.00	03100	INTENSIVE CARE UNIT		0	8,163	0.00	1,482	31.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	1,432	0.00	249	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	2,665	0.00	401	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT		0	1,251	0.00	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT		0	2,033	0.00	181	34.02
34.03	02400	NEURO INTENSIVE CARE		0	2,024	0.00	198	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT		0	7,036	0.00	0	34.04
43.00	04300	NURSERY		0	1,763	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	103,767		10,797	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost		
			9.00	13.00		
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0		34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0		34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	0	0		34.02
34.03	02400	NEURO INTENSIVE CARE	0	0		34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	0	0		34.04
43.00	04300	NURSERY	0	0		43.00
200.00		Total (lines 30 through 199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet D Part IV | Date/Time Prepared: 12/21/2018 2:13 pm

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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	405,971	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		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	405,971	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet D Part IV Date/Time Prepared: 12/21/2018 2:13 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	169,963,448	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	18,714,165	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,547,231	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	60,762,623	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	178,470,306	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	128,813,494	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	7,874,753	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,451,197	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,261,908	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,083,565	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,739,211	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	36,459,312	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	11,444,679	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,996,622	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	405,971	405,971	172,404,824	0.002355	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	8,412,282	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	189,831,536	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	69,696,222	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	47,751,061	0.000000	92.00
200.00		Total (lines 50 through 199)	0	405,971	405,971	1,134,678,439		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet D Part IV Date/Time Prepared: 12/21/2018 2:13 pm

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	9,179,383	0	3,359,490	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	431,018	0	753,312	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	3,349,869	0	1,265,116	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	4,722,998	0	14,269,510	0	54.00
60.00	06000	LABORATORY	0.000000	5,436,365	0	6,182,265	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	535,629	0	87,096	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,372,128	0	236,988	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	516,616	0	20,165	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	215,730	0	3,523	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	90,369	0	107,374	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,234,412	0	1,554,127	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	562,776	0	192,409	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	767,817	0	153,800	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.002355	7,815,048	18,404	17,445,655	41,085	73.00
74.00	07400	RENAL DIALYSIS	0.000000	735,606	0	77,791	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	657,523	0	17,976,977	0	90.00
91.00	09100	EMERGENCY	0.000000	1,169,527	0	2,916,485	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	2,282,514	0	2,273,990	0	92.00
200.00		Total (lines 50 through 199)		42,075,328	18,404	68,876,073	41,085	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet D Part IV Date/Time Prepared: 12/21/2018 2:13 pm

Title XVIII | Hospital | PPS

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet D Part V Date/Time Prepared: 12/21/2018 2:13 pm

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	0.545524	3,359,490	0	0	1,832,682	50.00
51.00	05100	RECOVERY ROOM	0.486265	753,312	0	0	366,309	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3.655652	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.212544	1,265,116	0	0	268,893	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.348796	14,269,510	0	0	4,977,148	54.00
60.00	06000	LABORATORY	0.539651	6,182,265	69	0	3,336,265	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1.182526	87,096	0	0	102,993	62.00
65.00	06500	RESPIRATORY THERAPY	1.480393	236,988	0	0	350,835	65.00
66.00	06600	PHYSICAL THERAPY	0.752619	20,165	0	0	15,177	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.825467	3,523	0	0	2,908	67.00
68.00	06800	SPEECH PATHOLOGY	0.640873	107,374	0	0	68,813	68.00
69.00	06900	ELECTROCARDIOLOGY	0.484458	1,554,127	0	0	752,909	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.685842	192,409	0	0	131,962	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.506287	153,800	0	0	77,867	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.031370	17,445,655	40,730	834,732	17,992,925	73.00
74.00	07400	RENAL DIALYSIS	0.732916	77,791	0	0	57,014	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.072791	17,976,977	0	0	19,285,539	90.00
91.00	09100	EMERGENCY	0.878166	2,916,485	0	0	2,561,158	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.673880	2,273,990	0	0	1,532,396	92.00
200.00		Subtotal (see instructions)		68,876,073	40,799	834,732	53,713,793	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		68,876,073	40,799	834,732	53,713,793	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet D Part V Date/Time Prepared: 12/21/2018 2:13 pm

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
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	37	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	42,008	860,918		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		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)	42,045	860,918		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	42,045	860,918		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet D Part V Date/Time Prepared: 12/21/2018 2:13 pm

Title XIX | Hospital | Cost

		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	0.545524	0	1,096,673	0	0	50.00
51.00	05100	RECOVERY ROOM	0.486265	0	792,306	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3.655652	0	30,147	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.212544	0	1,906,691	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.348796	0	4,601,634	0	0	54.00
60.00	06000	LABORATORY	0.539651	0	2,207,071	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1.182526	0	67,527	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1.480393	0	2,934,648	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.752619	0	22,675	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.825467	0	6,123	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.640873	0	11,814	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.484458	0	716,358	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.685842	0	309,039	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.506287	0	219,127	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.031370	0	2,734,463	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.732916	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.072791	0	5,190,128	0	0	90.00
91.00	09100	EMERGENCY	0.878166	0	5,746,910	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.673880	0	3,052,825	0	0	92.00
200.00		Subtotal (see instructions)		0	31,646,159	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	31,646,159	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet D Part V Date/Time Prepared: 12/21/2018 2:13 pm

Title XIX | Hospital | Cost

		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	598,261	0		50.00
51.00	05100	RECOVERY ROOM	385,271	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	110,207	0		52.00
53.00	05300	ANESTHESIOLOGY	405,256	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,605,032	0		54.00
60.00	06000	LABORATORY	1,191,048	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	79,852	0		62.00
65.00	06500	RESPIRATORY THERAPY	4,344,432	0		65.00
66.00	06600	PHYSICAL THERAPY	17,066	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,054	0		67.00
68.00	06800	SPEECH PATHOLOGY	7,571	0		68.00
69.00	06900	ELECTROCARDIOLOGY	347,045	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	211,952	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	110,941	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,820,243	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	5,567,923	0		90.00
91.00	09100	EMERGENCY	5,046,741	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,057,238	0		92.00
200.00		Subtotal (see instructions)	24,911,133	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	24,911,133	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet D-1 | Date/Time Prepared: 12/21/2018 2:13 pm

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)	77,400	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	77,400	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)	58,913	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)	8,286	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)	134,722,225	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)	134,722,225	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)	134,722,225	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,740.60	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	14,422,612	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)	14,422,612	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet D-1 | Date/Time Prepared: 12/21/2018 2:13 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	20,504,923	8,163	2,511.93	1,482	3,722,680	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT	10,289,879	1,432	7,185.67	249	1,789,232	45.00
46.00	SURGICAL INTENSIVE CARE UNIT	7,798,881	2,665	2,926.41	401	1,173,490	46.00
46.01	PEDIATRIC INTENSIVE CARE UNIT	1,479,786	1,251	1,182.88	0	0	46.01
46.02	TRAUMA INTENSIVE CARE UNIT	13,621,841	2,033	6,700.36	181	1,212,765	46.02
46.03	NEURO INTENSIVE CARE	5,665,928	2,024	2,799.37	198	554,275	46.03
46.04	NEONATAL INTENSIVE CARE UNIT	10,548,225	7,036	1,499.18	0	0	46.04
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)	27,532,863	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	50,407,917	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)	3,290,857	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	3,067,627	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	6,358,484	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	44,049,433	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)	18,487	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,740.60	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	32,178,472	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet D-1 | Date/Time Prepared: 12/21/2018 2:13 pm

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	22,191,903	134,722,225	0.164723	32,178,472	5,300,534	90.00
91.00	Nursing School cost	0	134,722,225	0.000000	32,178,472	0	91.00
92.00	Allied health cost	0	134,722,225	0.000000	32,178,472	0	92.00
93.00	All other Medical Education	0	134,722,225	0.000000	32,178,472	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0124	Period: From 12/01/2017 To 11/30/2018	Worksheet D-1 Date/Time Prepared: 12/21/2018 2:13 pm
	Title XIX	Hospital	Cost

	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)	77,400	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	77,400	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)	58,913	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)	11,716	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)	1,763	15.00
16.00	Nursery days (title V or XIX only)	961	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)	133,726,008	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)	133,726,008	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)	133,726,008	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,727.73	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	20,242,085	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)	20,242,085	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet D-1 | Date/Time Prepared: 12/21/2018 2:13 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	5,459,311	1,763	3,096.60	961	2,975,833	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	20,504,923	8,163	2,511.93	1,665	4,182,363	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT	10,289,879	1,432	7,185.67	159	1,142,522	45.00
46.00	SURGICAL INTENSIVE CARE UNIT	7,798,881	2,665	2,926.41	441	1,290,547	46.00
46.01	PEDIATRIC INTENSIVE CARE UNIT	1,479,786	1,251	1,182.88	373	441,214	46.01
46.02	TRAUMA INTENSIVE CARE UNIT	13,621,841	2,033	6,700.36	357	2,392,029	46.02
46.03	NEURO INTENSIVE CARE	5,665,928	2,024	2,799.37	277	775,425	46.03
46.04	NEONATAL INTENSIVE CARE UNIT	10,548,225	7,036	1,499.18	3,165	4,744,905	46.04
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)	37,177,221	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	75,364,144	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)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	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)	18,487	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,727.73	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	31,940,545	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet D-1 | Date/Time Prepared: 12/21/2018 2:13 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	22,191,903	133,726,008	0.165951	31,940,545	5,300,565	90.00
91.00	Nursing School cost	0	133,726,008	0.000000	31,940,545	0	91.00
92.00	Allied health cost	0	133,726,008	0.000000	31,940,545	0	92.00
93.00	All other Medical Education	0	133,726,008	0.000000	31,940,545	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet D-3 | Date/Time Prepared: 12/21/2018 2:13 pm

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		17,775,030		30.00
31.00	03100	INTENSIVE CARE UNIT		4,296,495		31.00
33.00	03300	BURN INTENSIVE CARE UNIT		771,001		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		1,162,987		34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT		0		34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT		560,728		34.02
34.03	02400	NEURO INTENSIVE CARE		572,866		34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT		0		34.04
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.545524	9,179,383	5,007,574	50.00
51.00	05100	RECOVERY ROOM	0.486265	431,018	209,589	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3.655652	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.214070	3,349,869	717,106	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.348796	4,722,998	1,647,363	54.00
60.00	06000	LABORATORY	0.539651	5,436,365	2,933,740	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1.182526	535,629	633,395	62.00
65.00	06500	RESPIRATORY THERAPY	1.480393	1,372,128	2,031,289	65.00
66.00	06600	PHYSICAL THERAPY	0.752619	516,616	388,815	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.825467	215,730	178,078	67.00
68.00	06800	SPEECH PATHOLOGY	0.640873	90,369	57,915	68.00
69.00	06900	ELECTROCARDIOLOGY	0.484458	2,234,412	1,082,479	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.685842	562,776	385,975	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.506287	767,817	388,736	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.031370	7,815,048	8,060,206	73.00
74.00	07400	RENAL DIALYSIS	0.732916	735,606	539,137	74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.074162	657,523	706,286	90.00
91.00	09100	EMERGENCY	0.878166	1,169,527	1,027,039	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.673880	2,282,514	1,538,141	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		42,075,328	27,532,863	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)		42,075,328		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet D-3 | Date/Time Prepared: 12/21/2018 2:13 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		19,993,657		30.00
31.00	03100	INTENSIVE CARE UNIT		4,034,501		31.00
33.00	03300	BURN INTENSIVE CARE UNIT		553,530		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		1,257,851		34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT		790,999		34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT		856,447		34.02
34.03	02400	NEURO INTENSIVE CARE		884,777		34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT		8,749,913		34.04
43.00	04300	NURSERY		637,186		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.545524	12,945,851	7,062,272	50.00
51.00	05100	RECOVERY ROOM	0.486265	436,681	212,343	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3.655652	202,468	740,153	52.00
53.00	05300	ANESTHESIOLOGY	0.212544	4,888,092	1,038,935	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.348796	2,521,441	879,469	54.00
60.00	06000	LABORATORY	0.539651	6,210,440	3,351,470	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1.182526	675,982	799,366	62.00
65.00	06500	RESPIRATORY THERAPY	1.480393	3,747,649	5,547,993	65.00
66.00	06600	PHYSICAL THERAPY	0.752619	570,787	429,585	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.825467	255,483	210,893	67.00
68.00	06800	SPEECH PATHOLOGY	0.640873	134,737	86,349	68.00
69.00	06900	ELECTROCARDIOLOGY	0.484458	1,766,573	855,830	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.685842	1,015,017	696,141	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.506287	805,881	408,007	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.031370	11,656,425	12,022,087	73.00
74.00	07400	RENAL DIALYSIS	0.732916	402,832	295,242	74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.072791	851,781	913,783	90.00
91.00	09100	EMERGENCY	0.878166	16,451	14,447	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.673880	2,393,388	1,612,856	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		51,497,959	37,177,221	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)		51,497,959		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0124	Period: From 12/01/2017 To 11/30/2018	Worksheet E Part A Date/Time Prepared: 12/21/2018 2:13 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	13,817,966	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	2,763,593	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)	3,484,342	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	5,131,439	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	406.35	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)	522.08	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	36.60	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).	-85.00	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)	400.48	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	459.17	10.00
11.00	FTE count for residents in dental and podiatric programs.	14.62	11.00
12.00	Current year allowable FTE (see instructions)	415.10	12.00
13.00	Total allowable FTE count for the prior year.	414.86	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.	412.60	14.00
15.00	Sum of lines 12 through 14 divided by 3.	414.19	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	414.19	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	1.019294	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.982522	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.982522	21.00
22.00	IME payment adjustment (see instructions)	7,149,587	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	2,212,558	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)	58.69	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)	7,149,587	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	2,212,558	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	13.48	30.00
31.00	Percentage of Medicaid patient days (see instructions)	38.96	31.00
32.00	Sum of lines 30 and 31	52.44	32.00
33.00	Allowable disproportionate share percentage (see instructions)	32.48	33.00
34.00	Disproportionate share adjustment (see instructions)	1,346,423	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0124	Period: From 12/01/2017 To 11/30/2018	Worksheet E Part A Date/Time Prepared: 12/21/2018 2:13 pm
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	28,048,514	52,476,132	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	23,360,962	8,769,969	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	32,130,931		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)	60,692,842		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)		62,905,400	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,831,350	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).		2,810,268	52.00
53.00	Nursing and Allied Health Managed Care payment		9,159	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)		18,404	58.00
59.00	Total (sum of amounts on lines 49 through 58)		68,574,581	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		68,574,581	61.00
62.00	Deductibles billed to program beneficiaries		1,676,596	62.00
63.00	Coinsurance billed to program beneficiaries		95,498	63.00
64.00	Allowable bad debts (see instructions)		297,634	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		193,462	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		56,370	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		66,995,949	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)		205,436	70.93
70.94	HRR adjustment amount (see instructions)		-53,524	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0124	Period: From 12/01/2017 To 11/30/2018	Worksheet E Part A Date/Time Prepared: 12/21/2018 2:13 pm
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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		67,147,861	71.00
71.01	Sequestration adjustment (see instructions)		1,342,957	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		56,390,014	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)		9,414,890	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		132,235	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		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)	1.0096200000	1.0127000000	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)	0.9968	1.0000	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

CALCULATION OF DSH PAYMENT PERCENTAGE | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet DSH | Date/Time Prepared: 12/21/2018 2:13 pm

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		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
	CALCULATION OF THE DSH PAYMENT PERCENTAGE						
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	13.48	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	38.96	0.00			38.96	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	52.44	0.00			38.96	3.00
4.00	Provider Type * (urban, rural,SCH, RRC, pickle - If pickle worksheet NA)	Urban				Urban	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	406.35	0.00			406.35	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	32.48	0.00			21.36	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	Yes				No	9.00
10.00	S-2, Line 45	Yes				Yes	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 geater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	13.48	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	No				No	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	14.00
	CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS						
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	16,002	0			16,002	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	3,112	0			3,112	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	14,530	0			14,530	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	0	0			0	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	33,644	0			33,644	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	85,280	0			85,280	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	1,068	0			1,068	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	86,348	0			86,348	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	38.96	0.00			38.96	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet DSH | Date/Time Prepared: 12/21/2018 2:13 pm

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		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE						
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	32.48		0.00	True	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	False	29.00
30.00	Line 28 or 29 as applicable		32.48		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		32.48		0.00		31.00

		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
	DETERMINATION OF PROVIDER TYPE						
32.00	Does the hospital qualify under the Pickle ammendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00
35.00	Is this a Sole Cummunity hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban				Urban	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE	Provider CCN: 14-0124	Period: From 12/01/2017 To 11/30/2018	Worksheet DSH Date/Time Prepared: 12/21/2018 2:13 pm
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		Revised Percentage 6.00		
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE			
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	21.36		28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	0.00		29.00
30.00	Line 28 or 29 as applicable	21.36		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	21.36		31.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 12/21/2018 2:13 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	13,817,966	0	13,817,966		13,817,966	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,763,593	0		2,763,593	2,763,593	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	3,484,342	0	2,903,618	580,724	3,484,342	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	5,131,439	0	4,276,199	855,240	5,131,439	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.982522	0.982522	0.982522	0.982522		5.00
6.00	IME payment adjustment (see instructions)	22.00	7,149,587	0	5,957,989	1,191,598	7,149,587	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	2,212,558	0	2,212,558	0	2,212,558	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	7,149,587	0	5,957,989	1,191,598	7,149,587	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	2,212,558	0	2,212,558	0	2,212,558	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.3248	0.3248	0.3248	0.3248		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	1,346,423	0	1,122,019	224,404	1,346,423	11.00
11.01	Uncompensated care payments	36.00	32,130,931	0	23,360,962	8,769,969	32,130,931	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	60,692,842	0	47,162,554	13,530,288	60,692,842	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	62,905,400	0	49,375,112	13,530,288	62,905,400	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,831,350	0	2,359,457	471,893	2,831,350	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 12/21/2018 2:13 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	51,734,569	14,002,181	65,736,750	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,350,381	0	1,125,317	225,064	1,350,381	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	618,075	0	515,062	103,013	618,075	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.5270	0.5270	0.5270	0.5270		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	711,651	0	593,042	118,609	711,651	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1120	0.1120	0.1120	0.1120		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	151,243	0	126,036	25,207	151,243	25.00
26.00	Total prospective capital payments (see instructions)	12.00	2,831,350	0	2,359,457	471,893	2,831,350	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.250000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				3,500,545	3,500,545	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 12/21/2018 2:13 pm

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		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	13,817,966	13,817,966		13,817,966	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,763,593		2,763,593	2,763,593	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	3,484,342	2,903,618	580,724	3,484,342	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	5,131,439	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.982522	0.982522	0.982522		5.00
6.00	IME payment adjustment (see instructions)	22.00	7,149,587	5,957,989	1,191,598	7,149,587	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	2,212,558	2,212,558	0	2,212,558	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	7,149,587	5,957,989	1,191,598	7,149,587	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	2,212,558	2,212,558	0	2,212,558	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.3248	0.3248	0.3248		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	1,346,423	1,122,019	224,404	1,346,423	11.00
11.01	Uncompensated care payments	36.00	32,130,931	23,360,962	8,769,969	32,130,931	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	60,692,842	47,162,554	13,530,288	60,692,842	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	62,905,400	49,375,112	13,530,288	62,905,400	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,831,350	2,359,457	471,893	2,831,350	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			51,734,569	14,002,181	65,736,750	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 12/21/2018 2:13 pm

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		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	1,350,381	1,125,317	225,064	1,350,381	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	618,075	515,062	103,013	618,075	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	0.5270	0.5270	0.5270		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	711,651	593,042	118,609	711,651	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1120	0.1120	0.1120		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	151,243	126,036	25,207	151,243	25.00
26.00	Total prospective capital payments (see instructions)	12.00	2,831,350	2,359,457	471,893	2,831,350	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	205,436	171,197	34,239	205,436	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	-53,524	-44,603	-8,921	-53,524	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0124	Period: From 12/01/2017 To 11/30/2018	Worksheet E Part B Date/Time Prepared: 12/21/2018 2:13 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	902,963	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	53,672,708	2.00
3.00	OPPS payments	22,128,040	3.00
4.00	Outlier payment (see instructions)	1,771,740	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	41,085	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	902,963	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	875,531	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)	875,531	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)	875,531	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	27,432	20.00
21.00	Lesser of cost or charges (see instructions)	875,531	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)	23,940,865	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	5,237,709	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)	19,578,687	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	3,044,908	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)	22,623,595	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	22,623,595	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)	3,096,892	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	2,012,980	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	316,813	36.00
37.00	Subtotal (see instructions)	24,636,575	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)	24,636,575	40.00
40.01	Sequestration adjustment (see instructions)	492,732	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	22,732,332	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	1,411,511	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0124	Period: From 12/01/2017 To 11/30/2018	Worksheet E Part B Date/Time Prepared: 12/21/2018 2:13 pm
	Title XVIII	Hospital	PPS

		Overrides	
		1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 12/21/2018 2:13 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		56,942,391		22,302,658	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	05/17/2018	429,674	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	05/17/2018	552,377		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)		-552,377		429,674	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)		56,390,014		22,732,332	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		9,414,890		1,411,511	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		65,804,904		24,143,843	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: 14-0124	Period: From 12/01/2017 To 11/30/2018	Worksheet E-1 Part II Date/Time Prepared: 12/21/2018 2:13 pm
	Title XVIII	Hospital	PPS

			1.00
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00
		Overrides	
		1.00	
	CONTRACTOR OVERRIDES		
108.00	Override of HIT payment		108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0124	Period: From 12/01/2017 To 11/30/2018	Worksheet E-3 Part VII Date/Time Prepared: 12/21/2018 2:13 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	75,364,144		1.00
2.00	Medical and other services		24,911,133	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	75,364,144	24,911,133	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	75,364,144	24,911,133	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	51,497,959	31,646,159	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	51,497,959	31,646,159	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	51,497,959	31,646,159	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	6,735,026	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	23,866,185	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	51,497,959	24,911,133	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	51,497,959	24,911,133	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	23,866,185	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	51,497,959	24,911,133	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	51,497,959	24,911,133	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	51,497,959	24,911,133	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	51,497,959	24,911,133	40.00
41.00	Interim payments	51,497,959	24,911,133	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00
	OVERRIDES			
109.00	Override Ancillary service charges (line 9)	0	0	109.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet E-4 | Date/Time Prepared: 12/21/2018 2:13 pm

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				1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			526.48	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			65.83	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			-60.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts			400.65	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			462.44	6.00
7.00	Enter the lesser of line 5 or line 6			400.65	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	198.73	218.15	416.88	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	172.18	189.00	361.18	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		13.91		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	172.18	202.91		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	166.68	208.89		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	175.04	200.56		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	171.30	204.12		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	171.30	204.12		17.00
18.00	Per resident amount	99,801.35	98,956.36		18.00
19.00	Approved amount for resident costs	17,095,971	20,198,972	37,294,943	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			61.79	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			37,294,943	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions)	10,797	2,891		26.00
27.00	Total Inpatient Days (see instructions)	84,585	84,585		27.00
28.00	Ratio of inpatient days to total inpatient days	0.127647	0.034179		28.00
29.00	Program direct GME amount	4,760,588	1,274,704		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		180,116		30.00
31.00	Net Program direct GME amount			5,855,176	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 14-0124	Period: From 12/01/2017 To 11/30/2018	Worksheet E-4 Date/Time Prepared: 12/21/2018 2:13 pm
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		1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)		
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)	0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)	8,412,282	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)	0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)	556	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)	0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY		
	Part A Reasonable Cost		
37.00	Reasonable cost (see instructions)	50,407,917	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)	0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)	0	39.00
40.00	Primary payer payments (see instructions)	0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	50,407,917	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	54,616,756	42.00
43.00	Primary payer payments (see instructions)	0	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	54,616,756	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	105,024,673	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.479963	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.520037	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	5,855,176	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	2,810,268	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	3,044,908	50.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet G | Date/Time Prepared: 12/21/2018 2:13 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	320,785,004	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	253,142,250	0	0	0	4.00
5.00	Other receivable	85,869,957	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	14,546,010	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	528,705,441	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)	1,203,048,662	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	990,911	0	0	0	12.00
13.00	Land improvements	2,717,512	0	0	0	13.00
14.00	Accumulated depreciation	-2,076,352	0	0	0	14.00
15.00	Buildings	703,324,991	0	0	0	15.00
16.00	Accumulated depreciation	-329,307,894	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	20,776,061	0	0	0	19.00
20.00	Accumulated depreciation	-19,590,545	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	183,456,708	0	0	0	23.00
24.00	Accumulated depreciation	-158,999,012	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)	401,292,380	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	630,937,510	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	630,937,510	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	2,235,278,552	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	130,544,777	0	0	0	37.00
38.00	Salaries, wages, and fees payable	60,262,511	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	1,096,117	0	0	0	43.00
44.00	Other current liabilities	86,933,217	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	278,836,622	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	5,205,225,165	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	5,205,225,165	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	5,484,061,787	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-3,248,783,235				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)	-3,248,783,235	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	2,235,278,552	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet G-1 | Date/Time Prepared: 12/21/2018 2:13 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-3,242,438,967		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-67,953,977				2.00
3.00	Total (sum of line 1 and line 2)		-3,310,392,944		0		3.00
4.00	OTHER	61,609,709		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)		61,609,709		0		10.00
11.00	Subtotal (line 3 plus line 10)		-3,248,783,235		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)		-3,248,783,235		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	OTHER		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: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 12/21/2018 2:13 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	132,680,674		132,680,674	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)	132,680,674		132,680,674	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	24,114,262		24,114,262	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT	4,465,226		4,465,226	13.00
14.00	SURGICAL INTENSIVE CARE UNIT	7,538,160		7,538,160	14.00
14.01	PEDIATRIC INTENSIVE CARE UNIT	3,731,961		3,731,961	14.01
14.02	TRAUMA INTENSIVE CARE UNIT	6,257,865		6,257,865	14.02
14.03	NEURO INTENSIVE CARE	5,782,597		5,782,597	14.03
14.04	NEONATAL INTENSIVE CARE UNIT	20,068,582		20,068,582	14.04
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	71,958,653		71,958,653	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	204,639,327		204,639,327	17.00
18.00	Ancillary services	359,338,721	352,607,015	711,945,736	18.00
19.00	Outpatient services	10,984,772	557,149,192	568,133,964	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 Patient Service Revenue	79,419,855	37,621,617	117,041,472	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	654,382,675	947,377,824	1,601,760,499	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		909,778,681		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)		909,778,681		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet G-3 | Date/Time Prepared: 12/21/2018 2:13 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,601,760,499	1.00
2.00	Less contractual allowances and discounts on patients' accounts	779,416,345	2.00
3.00	Net patient revenues (line 1 minus line 2)	822,344,154	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	909,778,681	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-87,434,527	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	294,745	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
24.01	Misc Income	11,764,384	24.01
24.02	Revenue from county	5,705,308	24.02
24.03	EHR Incentive Revenue	1,716,113	24.03
25.00	Total other income (sum of lines 6-24)	19,480,550	25.00
26.00	Total (line 5 plus line 25)	-67,953,977	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)	-67,953,977	29.00

ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS

Provider CCN: 14-0124 | Component CCN: 14-2313 | Period: From 12/01/2017 To 11/30/2018 | Worksheet I-1 | Date/Time Prepared: 12/21/2018 2:13 pm

Renal Dialysis

		Total Costs	Basis	Statistics	FTEs per 2080 Hours	
		1.00	2.00	3.00	4.00	
1.00	REGISTERED NURSES	1,486,045	HOURS OF SERVICE	16,748.00	8.05	1.00
2.00	LICENSED PRACTICAL NURSES	0	HOURS OF SERVICE	0.00	0.00	2.00
3.00	NURSES AIDES	62,674	HOURS OF SERVICE	2,831.00	1.36	3.00
4.00	TECHNICIANS	383,662	HOURS OF SERVICE	13,156.00	6.33	4.00
5.00	SOCIAL WORKERS	0	HOURS OF SERVICE	0.00	0.00	5.00
6.00	DIETICIANS	0	HOURS OF SERVICE	0.00	0.00	6.00
7.00	PHYSICIANS	559,264	ACCUMULATED COST			7.00
8.00	NON-PATIENT CARE SALARY	85,617	ACCUMULATED COST			8.00
9.00	SUBTOTAL (SUM OF LINES 1-8)	2,577,262				9.00
10.00	EMPLOYEE BENEFITS	0	SALARY			10.00
11.00	CAPITAL RELATED COSTS-BLDGS. & FIXTURES	0	SQUARE FEET			11.00
12.00	CAPITAL RELATED COSTS-MOV. EQUIP.	0	PERCENTAGE OF TIME			12.00
13.00	MACHINE COSTS & REPAIRS	0	PERCENTAGE OF TIME			13.00
14.00	SUPPLIES	9,118	REQUISITIONS			14.00
15.00	DRUGS	0	REQUISITIONS			15.00
16.00	OTHER	171,796	ACCUMULATED COST			16.00
17.00	SUBTOTAL (SUM OF LINES 9-16)*	2,758,176				17.00
18.00	CAPITAL RELATED COSTS-BLDGS. & FIXTURES	50,079	SQUARE FEET			18.00
19.00	CAPITAL RELATED COSTS-MOV. EQUIP.	19,385	PERCENTAGE OF TIME			19.00
20.00	EMPLOYEE BENEFITS DEPARTMENT	1,156,822	SALARY			20.00
21.00	ADMINISTRATIVE & GENERAL	1,704,573	ACCUMULATED COST			21.00
22.00	MAINT./REPAIRS-OPER-HOUSEKEEPING	191,285	SQUARE FEET			22.00
23.00	MEDICAL EDUCATION PROGRAM COSTS	0				23.00
24.00	CENTRAL SERVICE & SUPPLIES	3,253	REQUISITIONS			24.00
25.00	PHARMACY	0	REQUISITIONS			25.00
26.00	OTHER ALLOCATED COSTS	281,924	ACCUMULATED COST			26.00
27.00	SUBTOTAL (SUM OF LINES 17-26)*	6,165,497				27.00
28.00	LABORATORY (SEE INSTRUCTIONS)	0	CHARGES	0		28.00
29.00	RESPIRATORY THERAPY (SEE INSTRUCTIONS)	0	CHARGES	0		29.00
30.00	OTHER ANCILLARY SERVICE COST CENTERS	0	CHARGES	0		30.00
31.00	TOTAL COSTS (SUM OF LINES 27-30)	6,165,497				31.00

* Line 17, column 1 should agree with Worksheet A, column 7 for line 74 or line 94 as appropriate, and line 27, column 1 should agree with Worksheet B, Part I, column 24, less the sum of columns 21 and 22, for line 74 or line 94 as appropriate.

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES

Provider CCN: 14-0124 | Component CCN: 14-2313 | Period: From 12/01/2017 To 11/30/2018 | Worksheet I-2 | Date/Time Prepared: 12/21/2018 2:13 pm

Renal Dialysis

		Capital Related Costs		Direct Patient Care Salary				
		Building	Equipment	RNs	Other	Employee Benefits Department	Drugs	
		1.00	2.00	3.00	4.00	5.00	6.00	
1.00	Total Renal Department Costs	241,364	19,385	1,486,045	446,336	1,156,822	0	1.00
	MAINTENANCE							
2.00	Hemodialysis	157,825	12,676	971,705	291,853	756,431	0	2.00
2.01	AKI-Hemodialysis	0	0	0	0	0	0	2.01
3.00	Intermittent Peritoneal	0	0	0	0	0	0	3.00
3.01	AKI-Intermittent Peritoneal	0	0	0	0	0	0	3.01
	TRAINING							
4.00	Hemodialysis	0	0	0	0	0	0	4.00
5.00	Intermittent Peritoneal	0	0	0	0	0	0	5.00
6.00	CAPD	0	0	0	0	0	0	6.00
7.00	CCPD	0	0	0	0	0	0	7.00
	HOME							
8.00	Hemodialysis	0	0	0	0	0	0	8.00
9.00	Intermittent Peritoneal	0	0	0	0	0	0	9.00
10.00	CAPD	0	0	0	0	0	0	10.00
11.00	CCPD	0	0	0	0	0	0	11.00
	OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis	83,539	6,709	514,340	154,483	400,391	0	12.00
13.00	Method II Home Patient	0	0	0	0	0	0	13.00
14.00	ESAs (included in Renal Department)						0	14.00
15.00								15.00
16.00	Other	0	0	0	0	0	0	16.00
17.00	Total (sum of lines 2 through 16)	241,364	19,385	1,486,045	446,336	1,156,822	0	17.00
18.00	Medical Educational Program Costs							18.00
19.00	Total Renal Costs (line 17 + line 18)							19.00

		Medical Supplies	Routine Ancillary Services	Subtotal (sum of cols. 1-8)	Overhead	Total (col. 9 + col. 10)		
		7.00	8.00	9.00	10.00	11.00		
1.00	Total Renal Department Costs	12,371	0	3,362,323	2,803,174	6,165,497		1.00
	MAINTENANCE							
2.00	Hemodialysis	8,089	0	2,198,579	1,832,958	4,031,537		2.00
2.01	AKI-Hemodialysis	0	0	0	0	0		2.01
3.00	Intermittent Peritoneal	0	0	0	0	0		3.00
3.01	AKI-Intermittent Peritoneal	0	0	0	0	0		3.01
	TRAINING							
4.00	Hemodialysis	0	0	0	0	0		4.00
5.00	Intermittent Peritoneal	0	0	0	0	0		5.00
6.00	CAPD	0	0	0	0	0		6.00
7.00	CCPD	0	0	0	0	0		7.00
	HOME							
8.00	Hemodialysis	0	0	0	0	0		8.00
9.00	Intermittent Peritoneal	0	0	0	0	0		9.00
10.00	CAPD	0	0	0	0	0		10.00
11.00	CCPD	0	0	0	0	0		11.00
	OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis	4,282	0	1,163,744	970,216	2,133,960		12.00
13.00	Method II Home Patient	0	0	0	0	0		13.00
14.00	ESAs (included in Renal Department)							14.00
15.00								15.00
16.00	Other	0	0	0	0	0		16.00
17.00	Total (sum of lines 2 through 16)	12,371	0	3,362,323	2,803,174	6,165,497		17.00
18.00	Medical Educational Program Costs					0		18.00
19.00	Total Renal Costs (line 17 + line 18)					6,165,497		19.00

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0124 | Component CCN: 14-2313 | Period: From 12/01/2017 To 11/30/2018 | Worksheet I-3 | Date/Time Prepared: 12/21/2018 2:13 pm

Renal Dialysis

			Capital Related Costs		Direct Patient Care Salary			
			Building (Square Feet)	Equipment (% of Time)	RNs (Hours)	Other (Hours)	Employee Benefits Department (Salary)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	Total Renal Department Costs		241,364	19,385	1,486,045	446,336	1,156,822	1.00
	MAINTENANCE							
2.00	Hemodialysis		3,701	3,701.00	3,701.00	3,701.00	3,701	2.00
2.01	AKI-Hemodialysis		0	0.00	0.00	0.00	0	2.01
3.00	Intermittent Peritoneal		0	0.00	0.00	0.00	0	3.00
3.01	AKI-Intermittent Peritoneal		0	0.00	0.00	0.00	0	3.01
	TRAINING							
4.00	Hemodialysis		0	0.00	0.00	0.00	0	4.00
5.00	Intermittent Peritoneal		0	0.00	0.00	0.00	0	5.00
6.00	CAPD		0	0.00	0.00	0.00	0	6.00
7.00	CCPD		0	0.00	0.00	0.00	0	7.00
	HOME							
8.00	Hemodialysis		0	0.00	0.00	0.00	0	8.00
9.00	Intermittent Peritoneal		0	0.00	0.00	0.00	0	9.00
10.00	CAPD		0	0.00	0.00	0.00	0	10.00
11.00	CCPD		0	0.00	0.00	0.00	0	11.00
	OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis Treatments	1,959	1,959	1,959.00	1,959.00	1,959.00	1,959	12.00
13.00	Method II Home Patient		0	0.00	0.00	0.00	0	13.00
14.00	ESAs							14.00
15.00								15.00
16.00	Other		0	0.00	0.00	0.00	0	16.00
17.00	Total Statistical Basis		5,660	5,660.00	5,660.00	5,660.00	5,660	17.00
18.00	Unit Cost Multiplier (line 1 ÷ line 17)		42.643816	3.424912	262.552120	78.857951	204.385512	18.00

		Drugs (Requist.)	Medical Supplies (Requist.)	Routine Ancillary Services (Charges)	Subtotal	Overhead (Accum. Cost)		
		6.00	7.00	8.00	9.00	10.00		
1.00	Total Renal Department Costs	0	12,371	0	3,362,323	2,803,174		1.00
	MAINTENANCE							
2.00	Hemodialysis	0	3,701	0				2.00
2.01	AKI-Hemodialysis	0	0	0				2.01
3.00	Intermittent Peritoneal	0	0	0				3.00
3.01	AKI-Intermittent Peritoneal	0	0	0				3.01
	TRAINING							
4.00	Hemodialysis	0	0	0				4.00
5.00	Intermittent Peritoneal	0	0	0				5.00
6.00	CAPD	0	0	0				6.00
7.00	CCPD	0	0	0				7.00
	HOME							
8.00	Hemodialysis	0	0	0				8.00
9.00	Intermittent Peritoneal	0	0	0				9.00
10.00	CAPD	0	0	0				10.00
11.00	CCPD	0	0	0				11.00
	OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis Treatments	0	1,959	0				12.00
13.00	Method II Home Patient	0	0	0				13.00
14.00	ESAs							14.00
15.00								15.00
16.00	Other	0	0	0				16.00
17.00	Total Statistical Basis	0	5,660	0		3,362,323		17.00
18.00	Unit Cost Multiplier (line 1 ÷ line 17)	0.000000	2.185689	0.000000		0.833702		18.00

COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS

Provider CCN: 14-0124 | Component CCN: 14-2313 | Period: From 12/01/2017 To 11/30/2018 | Worksheet I-4 | Date/Time Prepared: 12/21/2018 2:13 pm

Rate 0 | Renal Dialysis

		Number of Total Treatments	Total Cost (from Wkst. I-2, col. 11)	Average Cost of Treatments (col. 2 ÷ col. 1)	Number of Program Treatments	Total Program Expenses (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
1.00	Maintenance - Hemodialysis	3,701	4,031,537	1,089.31	2	2,179	1.00
2.00	Maintenance - Peritoneal Dialysis	0	0	0.00	0	0	2.00
3.00	Training - Hemodialysis	0	0	0.00	0	0	3.00
4.00	Training - Peritoneal Dialysis	0	0	0.00	0	0	4.00
5.00	Training - CAPD	0	0	0.00	0	0	5.00
6.00	Training - CCPD	0	0	0.00	0	0	6.00
7.00	Home Program - Hemodialysis	0	0	0.00	0	0	7.00
8.00	Home Program - Peritoneal Dialysis	0	0	0.00	0	0	8.00
		Patient Weeks			Patient Weeks		
		1.00	2.00	3.00	4.00	5.00	
9.00	Home Program - CAPD	0	0	0.00	0	0	9.00
10.00	Home Program - CCPD	0	0	0.00	0	0	10.00
11.00	Totals (sum of lines 1 through 8, cols. 1 and 4) (sum of lines 1 through 10, cols. 2, 5, and 6) (see instruction)	3,701	4,031,537		2	2,179	11.00
12.00	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3)) (see instruction)	3,701					12.00

		Total Program Payment	Average Payment Rate (col. 6 ÷ col. 4)	
		6.00	7.00	
1.00	Maintenance - Hemodialysis	556	278.00	1.00
2.00	Maintenance - Peritoneal Dialysis	0	0.00	2.00
3.00	Training - Hemodialysis	0	0.00	3.00
4.00	Training - Peritoneal Dialysis	0	0.00	4.00
5.00	Training - CAPD	0	0.00	5.00
6.00	Training - CCPD	0	0.00	6.00
7.00	Home Program - Hemodialysis	0	0.00	7.00
8.00	Home Program - Peritoneal Dialysis	0	0.00	8.00
		6.00	7.00	
9.00	Home Program - CAPD	0	0.00	9.00
10.00	Home Program - CCPD	0	0.00	10.00
11.00	Totals (sum of lines 1 through 8, cols. 1 and 4) (sum of lines 1 through 10, cols. 2, 5, and 6) (see instruction)	556		11.00
12.00	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3)) (see instruction)			12.00

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B | Provider CCN: 14-0124 | Period: From 12/01/2017 To 11/30/2018 | Worksheet I-5 | Date/Time Prepared: 12/21/2018 2:13 pm

		1.00	2.00	
	PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B			
1.00	Total expenses related to care of program beneficiaries (see instructions)	2,179		1.00
2.00	Total payment due (from Wkst. I-4, col. 6, line 11) (see instructions)	556	556	2.00
2.01	Total payment due (from Wkst. I-4, col. 6.01, line 11) (see instructions)			2.01
2.02	Total payment due(from Wkst. I-4, col. 6.02, line 11) (see instructions)			2.02
2.03	Total payment due (see instructions)	556	556	2.03
2.04	Outlier payments	0		2.04
3.00	Deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.00
3.01	Deductibles billed to Medicare (Part B) patients (see instructions)			3.01
3.02	Deductibles billed to Medicare (Part B) patients (see instructions)			3.02
3.03	Total deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.03
4.00	Coinsurance billed to Medicare (Part B) patients	111	111	4.00
4.01	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.01
4.02	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.02
4.03	Total coinsurance billed to Medicare (Part B) patients (see instructions)	111	111	4.03
5.00	Bad debts for deductibles and coinsurance, net of bad debt recoveries	0	0	5.00
5.01	Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2011 but before 1/1/2012			5.01
5.02	Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2012 but before 1/1/2013			5.02
5.03	Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014			5.03
5.04	100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2014	0	0	5.04
5.05	Allowable bad debts (sum of lines 5 through line 5.04)	0	0	5.05
6.00	Adjusted reimbursable bad debts (see instructions)	0		6.00
7.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		7.00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) patients (see instructions)	0	111	8.00
9.00	Program payment (see instructions)	445	445	9.00
10.00	Unrecovered from Medicare (Part B) patients (see instructions)			10.00
11.00	Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)	0		11.00
	PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE			
12.00	Total allowable expenses (see instructions)	4,031,537		12.00
13.00	Total composite costs (from Wkst. I-4, col. 2, line 11)	4,031,537		13.00
14.00	Facility specific composite cost percentage (line 13 divided by line 12)	1.000000		14.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0124	Period: From 12/01/2017 To 11/30/2018	Worksheet L Parts I-III Date/Time Prepared: 12/21/2018 2:13 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,350,381	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	618,075	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)	231.74	3.00
4.00	Number of interns & residents (see instructions)	414.19	4.00
5.00	Indirect medical education percentage (see instructions)	52.70	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)	711,651	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	13.48	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	38.96	8.00
9.00	Sum of lines 7 and 8	52.44	9.00
10.00	Allowable disproportionate share percentage (see instructions)	11.20	10.00
11.00	Disproportionate share adjustment (see instructions)	151,243	11.00
12.00	Total prospective capital payments (see instructions)	2,831,350	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