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: 14-0130	Period: From 09/01/2017 To 08/31/2018	Worksheet S Parts I-III Date/Time Prepared: 1/31/2019 1:20 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 1/31/2019 Time: 1:20 am
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 NORTHWESTERN LAKE FOREST HOSPITAL (14-0130) for the cost reporting period beginning 09/01/2017 and ending 08/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	1,758,957	356,623	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
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	1,758,957	356,623	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: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 1/31/2019 1:20 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 660 WESTMORELAND ROAD	PO Box:			1.00
2.00	City: LAKE FOREST	State: IL	Zip Code: 60045	County: LAKE	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	NORTHWESTERN LAKE FOREST HOSPITAL	140130	29404	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	NORTHWESTERN LAKE FOREST HOME HEALTH	147045	29404		07/01/1966	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	09/01/2017	08/31/2018	20.00
21.00	Type of Control (see instructions)	2		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.	1,421	1,018	0	20	2,351	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 1/31/2019 1:20 am

		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)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (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)	Y	Y	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)	N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 1/31/2019 1:20 am

		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: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 1/31/2019 1:20 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0130	Period: From 09/01/2017 To 08/31/2018	Worksheet S-2 Part I Date/Time Prepared: 1/31/2019 1:20 am

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 1/31/2019 1:20 am

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	660,892	386,864	4,629,961	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	HB0640	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 1/31/2019 1:20 am

		1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.				
141.00	Name: NORTHWESTERN MEMORIAL HEALTHCARE AND		Contractor's Name: NGS	Contractor's Number: 06101	141.00
142.00	Street: 251 E HURON ST		PO Box:		142.00
143.00	City: CHICAGO		State: IL	Zip Code: 60611	143.00

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

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

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

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

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.01	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)	09/01/2015	08/31/2016	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: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 1/31/2019 1:20 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	11/30/2018	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	12/01/2018	Y	12/01/2018	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 1/31/2019 1:20 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		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.	JOHN	VANDER LAAN	41.00
42.00	Enter the employer/company name of the cost report preparer.	NORTHWESTERN MEMORIAL HEALTHCARE		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(312) 926-6618	JVANDERL@NMH.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 1/31/2019 1:20 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-3 Part I Date/Time Prepared: 1/31/2019 1:20 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	102	38,135	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)		102	38,135	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	12	4,018	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		114	42,153	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	44.00	0	0		0	19.00
20.00	NURSING FACILITY	45.00	0	0		0	20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
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)		114				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)		7	2,555			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 1/31/2019 1:20 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	9,917	924	23,006			1.00
2.00	HMO and other (see instructions)	1,269	2,351				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)	9,917	924	23,006			7.00
8.00	INTENSIVE CARE UNIT	1,573	678	3,033			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		857	4,503			13.00
14.00	Total (see instructions)	11,490	2,459	30,542	23.71	1,165.30	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	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY		0	0	0.00	0.00	20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	11,171	0.00	35.20	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	58			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)				23.71	1,200.50	27.00
28.00	Observation Bed Days		0	4,964			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	64	1,884			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			194			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: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 1/31/2019 1:20 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,987	415	8,368	1.00
2.00	HMO and other (see instructions)			327	513		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	2,987	415	8,368	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	0.00					19.00
20.00	NURSING FACILITY	0.00					20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
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: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-3 Part II Date/Time Prepared: 1/31/2019 1:20 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	94,679,682	-1,194,373	93,485,309	2,573,434.00	36.33	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	1,419,170	0	1,419,170	49,319.00	28.78	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		3,673,701	0	3,673,701	90,682.00	40.51	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,482,649	0	1,482,649	20,520.00	72.25	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		1,387,185	0	1,387,185	12,186.00	113.83	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		27,266,355	0	27,266,355	640,152.00	42.59	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)		23,485,408	0	23,485,408			17.00
18.00	Wage-related costs (other) (see instructions)		174,120	0	174,120			18.00
19.00	Excluded areas		892,913	0	892,913			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		318,192	0	318,192			25.00
25.50	Home office wage-related (core)		6,081,067	0	6,081,067			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	113,514	0	113,514	4,498.00	25.24	26.00
27.00	Administrative & General	5.00	14,914,726	-1,194,373	13,720,353	243,046.00	56.45	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-3 Part II Date/Time Prepared: 1/31/2019 1:20 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	3,732,092	0	3,732,092	133,832.00	27.89	30.00
31.00	Laundry & Linen Service	8.00	266,642	0	266,642	17,159.00	15.54	31.00
32.00	Housekeeping	9.00	1,842,965	0	1,842,965	113,739.00	16.20	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,101	0	1,101	19.00	57.95	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	14,312	0	14,312	460.00	31.11	37.00
38.00	Nursing Administration	13.00	5,663,233	0	5,663,233	118,935.00	47.62	38.00
39.00	Central Services and Supply	14.00	959,027	0	959,027	44,600.00	21.50	39.00
40.00	Pharmacy	15.00	2,789,307	0	2,789,307	60,184.00	46.35	40.00
41.00	Medical Records & Medical Records Library	16.00	565,043	0	565,043	21,097.00	26.78	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-3 Part III Date/Time Prepared: 1/31/2019 1:20 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		93,260,512	-1,194,373	92,066,139	2,524,115.00	36.47	1.00
2.00	Excluded area salaries (see instructions)		3,673,701	0	3,673,701	90,682.00	40.51	2.00
3.00	Subtotal salaries (line 1 minus line 2)		89,586,811	-1,194,373	88,392,438	2,433,433.00	36.32	3.00
4.00	Subtotal other wages & related costs (see inst.)		30,136,189	0	30,136,189	672,858.00	44.79	4.00
5.00	Subtotal wage-related costs (see inst.)		29,740,595	0	29,740,595	0.00	33.65	5.00
6.00	Total (sum of lines 3 thru 5)		149,463,595	-1,194,373	148,269,222	3,106,291.00	47.73	6.00
7.00	Total overhead cost (see instructions)		30,861,962	-1,194,373	29,667,589	757,569.00	39.16	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-3 Part IV Date/Time Prepared: 1/31/2019 1:20 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	5,999,989	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	7,351,458	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	2,904,335	9.00
10.00	Dental, Hearing and Vision Plan	363,042	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	183,815	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)	726,084	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	0	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	6,731,296	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	176,544	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	81,622	22.00
23.00	Tuition Reimbursement	352,941	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	24,871,126	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COST	174,120	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-3 Part V Date/Time Prepared: 1/31/2019 1:20 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	1,482,649	24,871,126	1.00
2.00	Hospital	1,482,649	24,871,126	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	0	0	8.00
9.00	Hospital-Based NF	0	0	9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 14-0130 | Component CCN: 14-7045 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-4 | Date/Time Prepared: 1/31/2019 1:20 am

Home Health Agency I | PPS

						1.00	
0.00	County				LAKE		0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	0.00	0.00	0.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	8.93	0.00	8.93	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			17.11	0.00	17.11	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			6.30	0.00	6.30	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			1.68	0.00	1.68	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.59	0.00	0.59	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.78	0.00	1.78	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			16974			20.00
20.01				29404			20.01
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	4,980	842	183	156	6,161	21.00
22.00	Skilled Nursing Visit Charges	0	0	0	0	0	22.00
23.00	Physical Therapy Visits	2,990	262	36	133	3,421	23.00
24.00	Physical Therapy Visit Charges	0	0	0	0	0	24.00
25.00	Occupational Therapy Visits	716	133	2	52	903	25.00
26.00	Occupational Therapy Visit Charges	0	0	0	0	0	26.00
27.00	Speech Pathology Visits	0	0	0	0	0	27.00
28.00	Speech Pathology Visit Charges	0	0	0	0	0	28.00
29.00	Medical Social Service Visits	137	74	1	12	224	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	340	111	1	10	462	31.00
32.00	Home Health Aide Visit Charges	0	0	0	0	0	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	9,163	1,422	223	363	11,171	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	0	0	0	0	0	35.00
36.00	Total Number of Episodes (standard/non outlier)	0		0	0	0	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	0	0	0	0	0	38.00

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-5 | Date/Time Prepared: 1/31/2019 1:20 am

		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	0	0	0	0	0	0	1.00
2.00	Number of times per week patient receives dialysis	0.00	0.00	0.00	0.00	0.00	0.00	2.00
3.00	Average patient dialysis time including setup	0.00	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	0	0					5.00
6.00	Number of stations	0	0	0	0			6.00
7.00	Treatment capacity per day per station	0	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	4	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			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: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-5 | Date/Time Prepared: 1/31/2019 1:20 am

		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)		0	23.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet S-10 | Date/Time Prepared: 1/31/2019 1:20 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.211097	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	13,195,570	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	169,827,232	6.00
7.00	Medicaid cost (line 1 times line 6)	35,850,019	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)	22,654,449	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	22,654,449	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	22,661,801	491,056	23,152,857	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	4,783,838	491,056	5,274,894	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)	4,783,838	491,056	5,274,894	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)	10,741,008	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	477,838	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	735,136	27.01
28.00	Non-Medicare bad debt expense (see instructions)	10,005,872	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,369,508	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	7,644,402	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	30,298,851	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet A | Date/Time Prepared: 1/31/2019 1:20 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		15,138,999	15,138,999	0	15,138,999	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		10,233,141	10,233,141	0	10,233,141	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	113,514	-3,536,832	-3,423,318	0	-3,423,318	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,914,726	107,169,368	122,084,094	0	122,084,094	5.00
7.00	00700	OPERATION OF PLANT	3,732,092	12,399,062	16,131,154	0	16,131,154	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	266,642	544,142	810,784	0	810,784	8.00
9.00	00900	HOUSEKEEPING	1,842,965	2,263,620	4,106,585	0	4,106,585	9.00
10.00	01000	DIETARY	1,101	5,325,543	5,326,644	-2,228,556	3,098,088	10.00
11.00	01100	CAFETERIA	0	603,883	603,883	2,228,556	2,832,439	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	14,312	84,291	98,603	0	98,603	12.00
13.00	01300	NURSING ADMINISTRATION	5,663,233	2,504,721	8,167,954	0	8,167,954	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	959,027	1,909,580	2,868,607	0	2,868,607	14.00
15.00	01500	PHARMACY	2,789,307	35,596,705	38,386,012	-34,754,547	3,631,465	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	565,043	378,553	943,596	0	943,596	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,419,170	282,292	1,701,462	0	1,701,462	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	89,896	857,024	946,920	0	946,920	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,949,781	5,364,055	18,313,836	-1,234,195	17,079,641	30.00
31.00	03100	INTENSIVE CARE UNIT	2,590,967	1,490,310	4,081,277	-249,802	3,831,475	31.00
43.00	04300	NURSERY	983,312	274,362	1,257,674	373,796	1,631,470	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,333,879	20,669,059	30,002,938	-13,775,018	16,227,920	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,457,390	1,381,533	3,838,923	-443,291	3,395,632	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,620,911	3,429,505	10,050,416	0	10,050,416	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,548,594	839,027	2,387,621	-31,951	2,355,670	55.00
57.00	05700	CT SCAN	658,878	446,207	1,105,085	-260,062	845,023	57.00
58.00	05800	MRI	1,972,844	853,247	2,826,091	-196,458	2,629,633	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,354,224	3,657,915	5,012,139	-1,867,485	3,144,654	59.00
60.00	06000	LABORATORY	3,495,682	6,222,634	9,718,316	-1,094,970	8,623,346	60.00
65.00	06500	RESPIRATORY THERAPY	1,255,254	581,147	1,836,401	-148,708	1,687,693	65.00
66.00	06600	PHYSICAL THERAPY	2,217,789	597,976	2,815,765	-11,596	2,804,169	66.00
68.00	06800	SPEECH PATHOLOGY	884,331	540,961	1,425,292	-269,437	1,155,855	68.00
69.00	06900	ELECTROCARDIOLOGY	782,228	235,746	1,017,974	-21,480	996,494	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	250,312	113,371	363,683	-19,178	344,505	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	11,689,645	11,689,645	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,937,012	7,937,012	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	35,286,619	35,286,619	73.00
76.97	07697	CARDIAC REHABILITATION	643,354	205,279	848,633	0	848,633	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	1,324,244	675,512	1,999,756	0	1,999,756	90.01
90.02	09002	WOUND CLINIC	480,478	967,187	1,447,665	0	1,447,665	90.02
91.00	09100	EMERGENCY	6,045,469	3,179,645	9,225,114	-908,894	8,316,220	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	785,032	271,832	1,056,864	0	1,056,864	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,052,223	1,047,690	4,099,913	0	4,099,913	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	94,058,204	244,798,292	338,856,496	0	338,856,496	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	143,310	84,960	228,270	0	228,270	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	401,668	3,620,045	4,021,713	0	4,021,713	192.00
194.00	07950	HEALTH & FITNESS CENTER	76,500	126,257	202,757	0	202,757	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	94,679,682	248,629,554	343,309,236	0	343,309,236	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet A | Date/Time Prepared: 1/31/2019 1:20 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,129,013	16,268,012		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-346,195	9,886,946		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,239,557	1,816,239		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-13,174,153	108,909,941		5.00
7.00	00700	OPERATION OF PLANT	-1,461,358	14,669,796		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	810,784		8.00
9.00	00900	HOUSEKEEPING	0	4,106,585		9.00
10.00	01000	DIETARY	-1,144,538	1,953,550		10.00
11.00	01100	CAFETERIA	-259,980	2,572,459		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	-55,701	42,902		12.00
13.00	01300	NURSING ADMINISTRATION	0	8,167,954		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,868,607		14.00
15.00	01500	PHARMACY	-1,229	3,630,236		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	943,596		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	1,701,462		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	946,920		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	17,079,641		30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,831,475		31.00
43.00	04300	NURSERY	0	1,631,470		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
45.00	04500	NURSING FACILITY	0	0		45.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	16,227,920		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,395,632		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-363,365	9,687,051		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	10,844	2,366,514		55.00
57.00	05700	CT SCAN	0	845,023		57.00
58.00	05800	MRI	-42,481	2,587,152		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,144,654		59.00
60.00	06000	LABORATORY	-394,349	8,228,997		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,687,693		65.00
66.00	06600	PHYSICAL THERAPY	-2,287	2,801,882		66.00
68.00	06800	SPEECH PATHOLOGY	0	1,155,855		68.00
69.00	06900	ELECTROCARDIOLOGY	-2,305	994,189		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	344,505		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	11,689,645		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,937,012		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	35,286,619		73.00
76.97	07697	CARDIAC REHABILITATION	-3,173	845,460		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.01	09001	OP PEDS ONC CLINIC	-60	1,999,696		90.01
90.02	09002	WOUND CLINIC	0	1,447,665		90.02
91.00	09100	EMERGENCY	0	8,316,220		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0	1,056,864		92.01
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	-542,798	3,557,115		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-11,414,558	327,441,938		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-179,785	48,485		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-5,232,120	-1,210,407		192.00
194.00	07950	HEALTH & FITNESS CENTER	-202,757	0		194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0		194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-17,029,220	326,280,016		200.00

RECLASSIFICATIONS | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet A-6 | Date/Time Prepared: 1/31/2019 1:20 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - MED SUPPLY & IMPLANT RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	11,689,645		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	7,937,012		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
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
	TOTALS		0	19,626,657		
	B - SALARY RECLASSED TO NON SALARY					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,194,373		1.00
	TOTALS		0	1,194,373		
	C - DRUG RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	35,286,619		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
	TOTALS		0	35,286,619		
	D - RECLASS SNF EXPENSES					
1.00		0.00	0	0		1.00
	TOTALS		0	0		
	H - NURSERY RECLASS					
1.00	NURSERY	43.00	288,450	104,974		1.00
	TOTALS		288,450	104,974		
	J - DIETARY RECLASS					
1.00	CAFETERIA	11.00	0	2,228,556		1.00
	TOTALS		0	2,228,556		
500.00	Grand Total: Increases		288,450	58,441,179		500.00

RECLASSIFICATIONS | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet A-6 | Date/Time Prepared: 1/31/2019 1:20 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - MED SUPPLY & IMPLANT RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	0	815,920	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	238,257	0		2.00
3.00	NURSERY	43.00	0	19,628	0		3.00
4.00	OPERATING ROOM	50.00	0	13,679,298	0		4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	0	430,283	0		5.00
7.00	RADIOLOGY-THERAPEUTIC	55.00	0	31,951	0		7.00
8.00	CT SCAN	57.00	0	83,456	0		8.00
9.00	MRI	58.00	0	78,282	0		9.00
10.00	CARDIAC CATHETERIZATION	59.00	0	1,835,502	0		10.00
11.00	LABORATORY	60.00	0	1,069,165	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	148,708	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	11,596	0		13.00
14.00	SPEECH PATHOLOGY	68.00	0	269,437	0		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	21,480	0		15.00
16.00	ELECTROENCEPHALOGRAPHY	70.00	0	19,178	0		16.00
17.00	EMERGENCY	91.00	0	874,516	0		17.00
	TOTALS		0	19,626,657			
	B - SALARY RECLASSED TO NON SALARY						
1.00	ADMINISTRATIVE & GENERAL	5.00	1,194,373	0	0		1.00
	TOTALS		1,194,373	0			
	C - DRUG RECLASS						
1.00		0.00	0	0	0		1.00
2.00	PHARMACY	15.00	0	34,754,547	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	24,851	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	11,545	0		4.00
5.00	OPERATING ROOM	50.00	0	95,720	0		5.00
6.00	DELIVERY ROOM & LABOR ROOM	52.00	0	13,008	0		6.00
7.00	LABORATORY	60.00	0	15,280	0		7.00
8.00	CT SCAN	57.00	0	176,606	0		8.00
9.00	MRI	58.00	0	118,176	0		9.00
10.00	CARDIAC CATHETERIZATION	59.00	0	31,983	0		10.00
11.00	LABORATORY	60.00	0	10,525	0		11.00
12.00	EMERGENCY	91.00	0	34,378	0		12.00
	TOTALS		0	35,286,619			
	D - RECLASS SNF EXPENSES						
1.00		0.00	0	0	0		1.00
	TOTALS		0	0			
	H - NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	288,450	104,974	0		1.00
	TOTALS		288,450	104,974			
	J - DIETARY RECLASS						
1.00	DIETARY	10.00	0	2,228,556	0		1.00
	TOTALS		0	2,228,556			
500.00	Grand Total: Decreases		1,482,823	57,246,806			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet A-7 Part I | Date/Time Prepared: 1/31/2019 1:20 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	52,023,598	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	184,621,168	365,162,780	0	365,162,780	1,270,802	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	60,248,424	55,653,079	0	55,653,079	9,294,953	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	296,893,190	420,815,859	0	420,815,859	10,565,755	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	296,893,190	420,815,859	0	420,815,859	10,565,755	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	52,023,598	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	548,513,146	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	106,606,550	0	5.00
6.00	Movable Equipment	0	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	707,143,294	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	707,143,294	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet A-7 Part II Date/Time Prepared: 1/31/2019 1:20 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	15,138,999	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	10,233,141	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	25,372,140	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	15,138,999	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	10,233,141	2.00
3.00	Total (sum of lines 1-2)	0	25,372,140	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 1/31/2019 1:20 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	548,513,146	0	548,513,146	0.837272	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	106,606,550	0	106,606,550	0.162728	0	2.00
3.00	Total (sum of lines 1-2)	655,119,696	0	655,119,696	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	16,268,012	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	9,886,946	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	26,154,958	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	0	0	0	0	16,268,012	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	9,886,946	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	26,154,958	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet A-8 | Date/Time Prepared: 1/31/2019 1:20 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	0			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-5,177,639			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
19.02	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.02
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	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet A-8 | Date/Time Prepared: 1/31/2019 1:20 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
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	LOSS ON DISPOSAL ADJUSTMENT	B	-311,121	CAP REL COSTS-BLDG & FIXT	1.00	9	33.00
33.01	HHA	B	-542,798	HOME HEALTH AGENCY	101.00	0	33.01
33.02	ADJUST TO MEDICARE BASIS	B	6,597,546	CAP REL COSTS-BLDG & FIXT	1.00	9	33.02
33.03	PAYOR INTEREST INCOME	B	-356,332	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	ADJUST TO MEDICARE BASIS	B	-346,195	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.04
33.05	RESEARCH REV	B	-166	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	RESEARCH REV	B	-1,229	PHARMACY	15.00	0	33.06
33.07	RESEARCH REV	B	-159	RADIOLOGY-DIAGNOSTIC	54.00	0	33.07
33.08	RESEARCH REV	B	-4,306	MRI	58.00	0	33.08
33.09	RESEARCH REV	B	-1,011	LABORATORY	60.00	0	33.09
33.10	RESEARCH REV	B	-1,405	ELECTROCARDIOLOGY	69.00	0	33.10
33.11	RESEARCH REV	B	-60	OP PEDS ONC CLINIC	90.01	0	33.11
33.12	ADJ EMP BEN PLAN 635200 3041	A	5,239,557	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13	SHARED SERVICES	B	-180,953	ADMINISTRATIVE & GENERAL	5.00	10	33.13
33.14	SHARED SERVICES	B	-274,318	DIETARY	10.00	0	33.14
33.15	SHARED SERVICES	B	-2,543	MAINTENANCE OF PERSONNEL	12.00	0	33.15
33.16	SHARED SERVICES	B	-33,508	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.16
33.17	RECLASS OF B PART II METHOD	B	-5,157,412	CAP REL COSTS-BLDG & FIXT	1.00	9	33.17
33.19	LOBBYING IHA	B	-28,203	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	LOBBYING AHA	B	-13,801	ADMINISTRATIVE & GENERAL	5.00	0	33.20
34.01	HAP OFFSET	B	-6,616,714	ADMINISTRATIVE & GENERAL	5.00	0	34.01
34.06	BUILDING RENT	B	-1,457,184	OPERATION OF PLANT	7.00	0	34.06
34.07	BUILDING RENT	B	-53,158	MAINTENANCE OF PERSONNEL	12.00	0	34.07
34.08	BUILDING RENT	B	-5,191,546	PHYSICIANS' PRIVATE OFFICES	192.00	0	34.08
34.10	CORP BILLING REV ADJ	B	499,197	ADMINISTRATIVE & GENERAL	5.00	0	34.10
34.11	CORP BILLING REV	B	-350,194	RADIOLOGY-DIAGNOSTIC	54.00	0	34.11
34.12	CORP BILLING REV ADJ	B	10,844	RADIOLOGY-THERAPEUTIC	55.00	0	34.12
34.13	CORP BILLING REV	B	-38,175	MRI	58.00	0	34.13
34.14	CORP BILLING REV	B	-351,568	LABORATORY	60.00	0	34.14
34.15	CORP BILLING REV	B	-900	ELECTROCARDIOLOGY	69.00	0	34.15
34.16	PHYSICIAN SALARY NO HOURS	B	-1,194,373	ADMINISTRATIVE & GENERAL	5.00	0	34.16
34.17	HEALTH AND FITNESS REMOVED	B	-202,757	HEALTH & FITNESS CENTER	194.00	0	34.17
34.18	FOOD SERV RELATED REV	B	-870,220	DIETARY	10.00	0	34.18
36.03	FOOD SERV RELATED REV	B	-259,980	CAFETERIA	11.00	0	36.03
38.00	LAB CHARGE RELATED	A	-13,012	RADIOLOGY-DIAGNOSTIC	54.00	0	38.00
38.01	LAB CHARGE RELATED	A	-41,770	LABORATORY	60.00	0	38.01
38.03	OTHER OP INCOME	A	-105,169	ADMINISTRATIVE & GENERAL	5.00	0	38.03
39.00	OTHER OP INCOME	A	-4,174	OPERATION OF PLANT	7.00	0	39.00
39.01	OTHER OP INCOME	A	-2,287	PHYSICAL THERAPY	66.00	0	39.01
39.02	OTHER OP INCOME	A	-3,173	CARDIAC REHABILITATION	76.97	0	39.02
40.01	OTHER OP INCOME	A	-179,785	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	40.01
43.00	OTHER OP INCOME	A	-7,066	PHYSICIANS' PRIVATE OFFICES	192.00	9	43.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-17,029,220				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: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 1/31/2019 1:20 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	0.00			0	0	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT CHARGE	61,873,448	67,051,087	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	VARIOUS	17,505,392	17,505,392	3.02
3.03	21.00	I&R SERVICES-SALARY & FRINGE	VARIOUS	621,513	621,513	3.03
3.04	54.00	RADIOLOGY-DIAGNOSTIC	VARIOUS	435,767	435,767	3.04
3.05	55.00	RADIOLOGY-THERAPEUTIC	VARIOUS	258,992	258,992	3.05
3.06	58.00	MRI	VARIOUS	8,191	8,191	3.06
3.07	60.00	LABORATORY	VARIOUS	200,039	200,039	3.07
3.08	68.00	SPEECH PATHOLOGY	VARIOUS	7,800	7,800	3.08
3.09	0.00			0	0	3.09
3.10	0.00			0	0	3.10
3.11	0.00			0	0	3.11
3.12	0.00			0	0	3.12
3.13	0.00			0	0	3.13
3.14	0.00			0	0	3.14
3.15	0.00			0	0	3.15
3.16	0.00			0	0	3.16
3.17	0.00			0	0	3.17
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.			80,911,142	86,088,781	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	B		0.00	NM HEALTHCARE	100.00	6.00
7.00	B		0.00	NM HOSPITAL	100.00	7.00
8.00	B		0.00	NM FOUNDATION	100.00	8.00
9.00	B		0.00	NM MEDICAL GROUP	100.00	9.00
9.01	B		0.00	LF HEALTH AND FITNESS INSTITUTE	100.00	9.01
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 1/31/2019 1:20 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	0	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
3.01	-5,177,639	0		3.01
3.02	0	0		3.02
3.03	0	0		3.03
3.04	0	0		3.04
3.05	0	0		3.05
3.06	0	0		3.06
3.07	0	0		3.07
3.08	0	0		3.08
3.09	0	0		3.09
3.10	0	0		3.10
3.11	0	0		3.11
3.12	0	0		3.12
3.13	0	0		3.13
3.14	0	0		3.14
3.15	0	0		3.15
3.16	0	0		3.16
3.17	0	0		3.17
4.00	0	0		4.00
5.00	-5,177,639	0		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	HEALTHCARE		6.00
7.00	HEALTHCARE		7.00
8.00	HEALTHCARE		8.00
9.00	HEALTHCARE		9.00
9.01	HEALTHCARE		9.01
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.

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet B Part I Date/Time Prepared: 1/31/2019 1:20 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	16,268,012	16,268,012				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	9,886,946		9,886,946			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,816,239	159,673	0	1,975,912		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	108,909,941	1,140,429	287,392	316,668	110,654,430	5.00
7.00	00700	OPERATION OF PLANT	14,669,796	3,519,267	304,426	79,232	18,572,721	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	810,784	45,430	21,478	5,661	883,353	8.00
9.00	00900	HOUSEKEEPING	4,106,585	173,671	7,098	39,126	4,326,480	9.00
10.00	01000	DIETARY	1,953,550	123,524	2,071	23	2,079,168	10.00
11.00	01100	CAFETERIA	2,572,459	34,516	2,852	0	2,609,827	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	42,902	166,939	0	304	210,145	12.00
13.00	01300	NURSING ADMINISTRATION	8,167,954	30,937	9,366	120,230	8,328,487	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,868,607	277,337	153,607	20,360	3,319,911	14.00
15.00	01500	PHARMACY	3,630,236	58,416	163,697	59,217	3,911,566	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	943,596	68,038	0	11,996	1,023,630	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,701,462	0	0	0	1,701,462	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	946,920	0	51,319	1,908	1,000,147	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,079,641	439,389	74,627	274,924	17,868,581	30.00
31.00	03100	INTENSIVE CARE UNIT	3,831,475	78,989	43,083	55,006	4,008,553	31.00
43.00	04300	NURSERY	1,631,470	9,351	30,686	20,876	1,692,383	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,227,920	1,305,034	2,962,076	198,158	20,693,188	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,395,632	145,898	126,089	52,170	3,719,789	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,687,051	404,764	2,842,057	140,562	13,074,434	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,366,514	251,213	991,079	32,877	3,641,683	55.00
57.00	05700	CT SCAN	845,023	18,785	52,266	13,988	930,062	57.00
58.00	05800	MRI	2,587,152	363,671	745,224	41,883	3,737,930	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,144,654	55,300	119,989	28,750	3,348,693	59.00
60.00	06000	LABORATORY	8,228,997	247,285	342,257	74,213	8,892,752	60.00
65.00	06500	RESPIRATORY THERAPY	1,687,693	3,567	53,828	26,649	1,771,737	65.00
66.00	06600	PHYSICAL THERAPY	2,801,882	330,422	13,083	47,084	3,192,471	66.00
68.00	06800	SPEECH PATHOLOGY	1,155,855	314,934	22,709	18,774	1,512,272	68.00
69.00	06900	ELECTROCARDIOLOGY	994,189	110,910	150,641	16,607	1,272,347	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	344,505	58,744	49,441	5,314	458,004	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,689,645	0	0	0	11,689,645	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,937,012	0	0	0	7,937,012	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,286,619	0	0	0	35,286,619	73.00
76.97	07697	CARDIAC REHABILITATION	845,460	15,981	14,395	13,658	889,494	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	1,999,696	164,971	5,933	28,114	2,198,714	90.01
90.02	09002	WOUND CLINIC	1,447,665	23,124	13,776	10,201	1,494,766	90.02
91.00	09100	EMERGENCY	8,316,220	394,636	180,702	128,345	9,019,903	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	1,056,864	85,010	20,456	16,666	1,178,996	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,557,115	963	10,578	64,799	3,633,455	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	327,441,938	10,621,118	9,868,281	1,964,343	321,764,810	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	48,485	15,417	919	3,042	67,863	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-1,210,407	5,631,477	17,746	8,527	4,447,343	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0	194.01
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)	326,280,016	16,268,012	9,886,946	1,975,912	326,280,016	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet B Part I | Date/Time Prepared: 1/31/2019 1:20 am

		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	110,654,430					5.00
7.00	00700	OPERATION OF PLANT	9,731,846	28,304,567				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	462,865	0	1,346,218			8.00
9.00	00900	HOUSEKEEPING	2,267,015	593,282	710,023	7,896,800		9.00
10.00	01000	DIETARY	1,089,455	291,753	0	124,425	3,584,801	10.00
11.00	01100	CAFETERIA	1,367,513	1,032,112	0	33,181	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	110,113	122,893	0	16,589	0	12.00
13.00	01300	NURSING ADMINISTRATION	4,364,011	1,394,788	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,739,587	258,478	0	82,949	0	14.00
15.00	01500	PHARMACY	2,049,606	920,110	0	49,770	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	536,368	265,939	0	182,489	0	16.00
17.00	01700	SOCIAL SERVICE	0	568,498	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	891,542	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	524,063	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,362,886	3,671,180	388,334	4,661,763	2,492,047	30.00
31.00	03100	INTENSIVE CARE UNIT	2,100,426	660,003	42,991	373,274	341,775	31.00
43.00	04300	NURSERY	886,785	78,127	98,548	116,130	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,842,941	5,295,631	24,260	862,675	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,949,117	1,218,981	29,284	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,850,820	2,017,314	0	199,079	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,908,191	834,609	0	0	0	55.00
57.00	05700	CT SCAN	487,339	156,939	0	0	0	57.00
58.00	05800	MRI	1,958,623	688,303	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,754,668	462,071	0	0	0	59.00
60.00	06000	LABORATORY	4,659,678	1,306,198	0	248,849	0	60.00
65.00	06500	RESPIRATORY THERAPY	928,365	29,844	0	74,655	0	65.00
66.00	06600	PHYSICAL THERAPY	1,672,810	1,842,193	6,019	91,245	0	66.00
68.00	06800	SPEECH PATHOLOGY	792,409	800,048	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	666,692	244,071	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	239,988	490,800	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,125,210	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,158,883	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,489,683	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	466,082	133,527	2,924	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	1,152,095	555,205	0	389,863	0	90.01
90.02	09002	WOUND CLINIC	783,236	193,215	43,835	0	0	90.02
91.00	09100	EMERGENCY	4,726,303	1,960,198	0	323,504	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	617,777	211,053	0	0	750,979	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,903,880	7,204	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	110,618,871	28,304,567	1,346,218	7,830,440	3,584,801	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	35,559	0	0	66,360	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0	194.01
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)	110,654,430	28,304,567	1,346,218	7,896,800	3,584,801	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet B Part I | Date/Time Prepared: 1/31/2019 1:20 am

		Cost Center Description	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	5,042,633					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	3,082	462,822				12.00
13.00	01300	NURSING ADMINISTRATION	281,524	0	14,368,810			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	105,328	0	0	5,506,253		14.00
15.00	01500	PHARMACY	150,672	0	0	0	7,081,724	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	65,958	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	9,068	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	934,481	0	4,441,073	12,816	4,987	30.00
31.00	03100	INTENSIVE CARE UNIT	160,403	0	1,024,693	9,430	2,317	31.00
43.00	04300	NURSERY	49,357	0	453,659	743	21	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	643,236	0	2,995,804	519,394	19,210	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	160,684	0	871,508	9,891	2,611	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	503,569	0	146,743	157,183	1,689	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	64,683	0	194,289	227	204	55.00
57.00	05700	CT SCAN	57,541	0	16,173	21,520	241	57.00
58.00	05800	MRI	144,089	0	11,989	42,737	362	58.00
59.00	05900	CARDIAC CATHETERIZATION	79,589	0	302,829	65,527	421	59.00
60.00	06000	LABORATORY	307,704	115,706	0	317,936	3,067	60.00
65.00	06500	RESPIRATORY THERAPY	79,216	0	0	15,267	79	65.00
66.00	06600	PHYSICAL THERAPY	225,297	115,706	0	8	0	66.00
68.00	06800	SPEECH PATHOLOGY	69,386	0	0	201	0	68.00
69.00	06900	ELECTROCARDIOLOGY	51,565	0	642	107	136	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	16,619	0	0	886	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,547,346	250	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,729,594	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	7,036,438	73.00
76.97	07697	CARDIAC REHABILITATION	42,098	0	168,988	12	7	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	103,813	0	502,372	448	1,980	90.01
90.02	09002	WOUND CLINIC	32,933	0	149,994	23,939	395	90.02
91.00	09100	EMERGENCY	366,249	231,410	2,095,278	13,543	6,899	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	116,574	0	312,949	151	409	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	192,358	0	620,779	12,362	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,017,076	462,822	14,309,762	5,501,268	7,081,723	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,548	0	59,048	3	1	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,009	0	0	4,982	0	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,042,633	462,822	14,368,810	5,506,253	7,081,724	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet B Part I Date/Time Prepared: 1/31/2019 1:20 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	Subtotal	
			16.00	17.00	21.00	22.00	24.00	
		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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,074,384					16.00
17.00	01700	SOCIAL SERVICE	0	568,498				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	2,593,004			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		1,533,278		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	108,324	568,498	2,593,004	1,533,278	48,641,252	30.00
31.00	03100	INTENSIVE CARE UNIT	20,313	0	0	0	8,744,178	31.00
43.00	04300	NURSERY	11,281	0	0	0	3,387,034	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	318,868	0	0	0	42,215,207	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	35,483	0	0	0	7,997,348	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	194,889	0	0	0	23,145,720	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	51,395	0	0	0	6,695,281	55.00
57.00	05700	CT SCAN	90,997	0	0	0	1,760,812	57.00
58.00	05800	MRI	123,194	0	0	0	6,707,227	58.00
59.00	05900	CARDIAC CATHETERIZATION	51,931	0	0	0	6,065,729	59.00
60.00	06000	LABORATORY	223,936	0	0	0	16,075,826	60.00
65.00	06500	RESPIRATORY THERAPY	40,278	0	0	0	2,939,441	65.00
66.00	06600	PHYSICAL THERAPY	27,867	0	0	0	7,173,616	66.00
68.00	06800	SPEECH PATHOLOGY	6,069	0	0	0	3,180,385	68.00
69.00	06900	ELECTROCARDIOLOGY	58,730	0	0	0	2,294,290	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,760	0	0	0	1,210,057	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	88,797	0	0	0	20,451,248	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	51,619	0	0	0	13,877,108	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	317,309	0	0	0	61,130,049	73.00
76.97	07697	CARDIAC REHABILITATION	3,038	0	0	0	1,706,170	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	16,670	0	0	0	4,921,160	90.01
90.02	09002	WOUND CLINIC	8,141	0	0	0	2,730,454	90.02
91.00	09100	EMERGENCY	206,304	0	0	0	18,949,591	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	9,222	0	0	0	3,198,110	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	5,969	0	0	0	6,376,007	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,074,384	568,498	2,593,004	1,533,278	321,573,300	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	236,382	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	4,470,334	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments			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)	2,074,384	568,498	2,593,004	1,533,278	326,280,016	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet B Part I | Date/Time Prepared: 1/31/2019 1:20 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-4,126,282	44,514,970		30.00
31.00	03100	INTENSIVE CARE UNIT	0	8,744,178		31.00
43.00	04300	NURSERY	0	3,387,034		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
45.00	04500	NURSING FACILITY	0	0		45.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	42,215,207		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,997,348		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	23,145,720		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	6,695,281		55.00
57.00	05700	CT SCAN	0	1,760,812		57.00
58.00	05800	MRI	0	6,707,227		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	6,065,729		59.00
60.00	06000	LABORATORY	0	16,075,826		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,939,441		65.00
66.00	06600	PHYSICAL THERAPY	0	7,173,616		66.00
68.00	06800	SPEECH PATHOLOGY	0	3,180,385		68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,294,290		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,210,057		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	20,451,248		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	13,877,108		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	61,130,049		73.00
76.97	07697	CARDIAC REHABILITATION	0	1,706,170		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.01	09001	OP PEDS ONC CLINIC	0	4,921,160		90.01
90.02	09002	WOUND CLINIC	0	2,730,454		90.02
91.00	09100	EMERGENCY	0	18,949,591		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0	3,198,110		92.01
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	6,376,007		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,126,282	317,447,018		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	236,382		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,470,334		192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0		194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0		194.01
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	-4,126,282	322,153,734		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet B Part II Date/Time Prepared: 1/31/2019 1:20 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	48,217	159,673	0	207,890	207,890	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,244,336	1,140,429	287,392	11,672,157	33,292	5.00
7.00	00700	OPERATION OF PLANT	1,161,002	3,519,267	304,426	4,984,695	8,337	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,836	45,430	21,478	72,744	596	8.00
9.00	00900	HOUSEKEEPING	23,086	173,671	7,098	203,855	4,117	9.00
10.00	01000	DIETARY	83,834	123,524	2,071	209,429	2	10.00
11.00	01100	CAFETERIA	7,074	34,516	2,852	44,442	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	353	166,939	0	167,292	32	12.00
13.00	01300	NURSING ADMINISTRATION	16,636	30,937	9,366	56,939	12,652	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	49,986	277,337	153,607	480,930	2,142	14.00
15.00	01500	PHARMACY	15,859	58,416	163,697	237,972	6,231	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,834	68,038	0	69,872	1,262	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	51,319	51,319	201	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	303,656	439,389	74,627	817,672	28,930	30.00
31.00	03100	INTENSIVE CARE UNIT	54,589	78,989	43,083	176,661	5,788	31.00
43.00	04300	NURSERY	6,462	9,351	30,686	46,499	2,197	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	33,184	1,305,034	2,962,076	4,300,294	20,852	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	100,828	145,898	126,089	372,815	5,490	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	399,892	404,764	2,842,057	3,646,713	14,791	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	45,398	251,213	991,079	1,287,690	3,460	55.00
57.00	05700	CT SCAN	12,982	18,785	52,266	84,033	1,472	57.00
58.00	05800	MRI	12,993	363,671	745,224	1,121,888	4,407	58.00
59.00	05900	CARDIAC CATHETERIZATION	38,217	55,300	119,989	213,506	3,025	59.00
60.00	06000	LABORATORY	90,628	247,285	342,257	680,170	7,809	60.00
65.00	06500	RESPIRATORY THERAPY	2,466	3,567	53,828	59,861	2,804	65.00
66.00	06600	PHYSICAL THERAPY	60,082	330,422	13,083	403,587	4,955	66.00
68.00	06800	SPEECH PATHOLOGY	0	314,934	22,709	337,643	1,976	68.00
69.00	06900	ELECTROCARDIOLOGY	7,428	110,910	150,641	268,979	1,747	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,677	58,744	49,441	113,862	559	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	15,981	14,395	30,376	1,437	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	30,534	164,971	5,933	201,438	2,958	90.01
90.02	09002	WOUND CLINIC	696	23,124	13,776	37,596	1,073	90.02
91.00	09100	EMERGENCY	137,136	394,636	180,702	712,474	13,506	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	7,275	85,010	20,456	112,741	1,754	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	28,825	963	10,578	40,366	6,819	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,037,001	10,621,118	9,868,281	33,526,400	206,673	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,417	919	16,336	320	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,631,477	17,746	5,649,223	897	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0	194.01
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)	13,037,001	16,268,012	9,886,946	39,191,959	207,890	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet B Part II Date/Time Prepared: 1/31/2019 1:20 am

		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	11,705,449					5.00
7.00	00700	OPERATION OF PLANT	1,029,467	6,022,499				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	48,963	0	122,303			8.00
9.00	00900	HOUSEKEEPING	239,812	126,235	64,505	638,524		9.00
10.00	01000	DIETARY	115,246	62,078	0	10,061	396,816	10.00
11.00	01100	CAFETERIA	144,660	219,607	0	2,683	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	11,648	26,149	0	1,341	0	12.00
13.00	01300	NURSING ADMINISTRATION	461,640	296,776	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	184,019	54,998	0	6,707	0	14.00
15.00	01500	PHARMACY	216,814	195,776	0	4,024	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	56,739	56,585	0	14,756	0	16.00
17.00	01700	SOCIAL SERVICE	0	120,962	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	94,310	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	55,437	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	990,438	781,135	35,280	376,943	275,854	30.00
31.00	03100	INTENSIVE CARE UNIT	222,190	140,432	3,906	30,182	37,833	31.00
43.00	04300	NURSERY	93,807	16,623	8,953	9,390	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,147,003	1,126,775	2,204	69,755	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	206,184	259,369	2,660	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	724,703	429,234	0	16,097	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	201,855	177,584	0	0	0	55.00
57.00	05700	CT SCAN	51,552	33,393	0	0	0	57.00
58.00	05800	MRI	207,190	146,454	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	185,615	98,317	0	0	0	59.00
60.00	06000	LABORATORY	492,916	277,926	0	20,122	0	60.00
65.00	06500	RESPIRATORY THERAPY	98,206	6,350	0	6,037	0	65.00
66.00	06600	PHYSICAL THERAPY	176,955	391,972	547	7,378	0	66.00
68.00	06800	SPEECH PATHOLOGY	83,824	170,230	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	70,525	51,932	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	25,387	104,430	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	647,945	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	439,941	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,955,952	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	49,304	28,411	266	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	121,873	118,134	0	31,524	0	90.01
90.02	09002	WOUND CLINIC	82,853	41,111	3,982	0	0	90.02
91.00	09100	EMERGENCY	499,964	417,081	0	26,158	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	65,351	44,907	0	0	83,129	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	201,399	1,533	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,701,687	6,022,499	122,303	633,158	396,816	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,762	0	0	5,366	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0	194.01
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)	11,705,449	6,022,499	122,303	638,524	396,816	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet B Part II | Date/Time Prepared: 1/31/2019 1:20 am

		Cost Center Description	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	411,392					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	251	206,713				12.00
13.00	01300	NURSING ADMINISTRATION	22,967	0	850,974			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,593	0	0	737,389		14.00
15.00	01500	PHARMACY	12,292	0	0	0	673,109	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,381	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	740	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	76,239	0	263,016	1,716	474	30.00
31.00	03100	INTENSIVE CARE UNIT	13,086	0	60,686	1,263	220	31.00
43.00	04300	NURSERY	4,027	0	26,867	99	2	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	52,477	0	177,423	69,557	1,826	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,109	0	51,614	1,325	248	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	41,083	0	8,691	21,050	161	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,277	0	11,507	30	19	55.00
57.00	05700	CT SCAN	4,694	0	958	2,882	23	57.00
58.00	05800	MRI	11,755	0	710	5,723	34	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,493	0	17,935	8,775	40	59.00
60.00	06000	LABORATORY	25,103	51,678	0	42,578	291	60.00
65.00	06500	RESPIRATORY THERAPY	6,463	0	0	2,045	7	65.00
66.00	06600	PHYSICAL THERAPY	18,380	51,678	0	1	0	66.00
68.00	06800	SPEECH PATHOLOGY	5,661	0	0	27	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,207	0	38	14	13	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,356	0	0	119	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	341,134	24	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	231,626	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	668,805	73.00
76.97	07697	CARDIAC REHABILITATION	3,434	0	10,008	2	1	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	8,469	0	29,752	60	188	90.01
90.02	09002	WOUND CLINIC	2,687	0	8,883	3,206	38	90.02
91.00	09100	EMERGENCY	29,880	103,357	124,090	1,814	656	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	9,510	0	18,534	20	39	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	15,693	0	36,765	1,656	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	409,307	206,713	847,477	736,722	673,109	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	616	0	3,497	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,469	0	0	667	0	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0	194.01
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)	411,392	206,713	850,974	737,389	673,109	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet B Part II Date/Time Prepared: 1/31/2019 1:20 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	Subtotal	
			16.00	17.00	21.00	22.00	24.00	
		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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	204,595					16.00
17.00	01700	SOCIAL SERVICE	0	120,962				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	94,310			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		107,697		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,683	120,962			3,779,342	30.00
31.00	03100	INTENSIVE CARE UNIT	2,003	0			694,250	31.00
43.00	04300	NURSERY	1,113	0			209,577	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0			0	44.00
45.00	04500	NURSING FACILITY	0	0			0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,462	0			6,999,628	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,499	0			916,313	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,220	0			4,921,743	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,069	0			1,692,491	55.00
57.00	05700	CT SCAN	8,974	0			187,981	57.00
58.00	05800	MRI	12,150	0			1,510,311	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,122	0			538,828	59.00
60.00	06000	LABORATORY	22,085	0			1,620,678	60.00
65.00	06500	RESPIRATORY THERAPY	3,972	0			185,745	65.00
66.00	06600	PHYSICAL THERAPY	2,748	0			1,058,201	66.00
68.00	06800	SPEECH PATHOLOGY	599	0			599,960	68.00
69.00	06900	ELECTROCARDIOLOGY	5,792	0			403,247	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	371	0			246,084	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,757	0			997,860	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,091	0			676,658	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,294	0			2,656,051	73.00
76.97	07697	CARDIAC REHABILITATION	300	0			123,539	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	1,644	0			516,040	90.01
90.02	09002	WOUND CLINIC	803	0			182,232	90.02
91.00	09100	EMERGENCY	20,346	0			1,949,326	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	909	0			336,894	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	589	0			304,820	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	204,595	120,962	0	0	33,307,799	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			29,897	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0			5,652,256	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0			0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0			0	194.01
200.00		Cross Foot Adjustments			94,310	107,697	202,007	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	204,595	120,962	94,310	107,697	39,191,959	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet B Part II | Date/Time Prepared: 1/31/2019 1:20 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	3,779,342		30.00
31.00	03100	INTENSIVE CARE UNIT	0	694,250		31.00
43.00	04300	NURSERY	0	209,577		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
45.00	04500	NURSING FACILITY	0	0		45.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	6,999,628		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	916,313		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,921,743		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,692,491		55.00
57.00	05700	CT SCAN	0	187,981		57.00
58.00	05800	MRI	0	1,510,311		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	538,828		59.00
60.00	06000	LABORATORY	0	1,620,678		60.00
65.00	06500	RESPIRATORY THERAPY	0	185,745		65.00
66.00	06600	PHYSICAL THERAPY	0	1,058,201		66.00
68.00	06800	SPEECH PATHOLOGY	0	599,960		68.00
69.00	06900	ELECTROCARDIOLOGY	0	403,247		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	246,084		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	997,860		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	676,658		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,656,051		73.00
76.97	07697	CARDIAC REHABILITATION	0	123,539		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.01	09001	OP PEDS ONC CLINIC	0	516,040		90.01
90.02	09002	WOUND CLINIC	0	182,232		90.02
91.00	09100	EMERGENCY	0	1,949,326		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0	336,894		92.01
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	304,820		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	33,307,799		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	29,897		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,652,256		192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0		194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0		194.01
200.00		Cross Foot Adjustments	0	202,007		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	39,191,959		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet B-1 | Date/Time Prepared: 1/31/2019 1:20 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (DV SQUARE FEET)	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	9,380,512					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		5,939,035				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	92,071	0	93,070,498			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	657,598	172,635	14,914,726	-110,654,430	211,178,243	5.00
7.00	00700	OPERATION OF PLANT	2,029,291	182,867	3,732,092	0	18,572,721	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	26,196	12,902	266,642	0	883,353	8.00
9.00	00900	HOUSEKEEPING	100,143	4,264	1,842,965	0	4,326,480	9.00
10.00	01000	DIETARY	71,227	1,244	1,101	0	2,079,168	10.00
11.00	01100	CAFETERIA	19,903	1,713	0	0	2,609,827	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	96,261	0	14,312	0	210,145	12.00
13.00	01300	NURSING ADMINISTRATION	17,839	5,626	5,663,233	0	8,328,487	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	159,919	92,271	959,027	0	3,319,911	14.00
15.00	01500	PHARMACY	33,684	98,332	2,789,307	0	3,911,566	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	39,232	0	565,043	0	1,023,630	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	1,701,462	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	30,827	89,896	0	1,000,147	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	253,362	44,828	12,949,781	0	17,868,581	30.00
31.00	03100	INTENSIVE CARE UNIT	45,547	25,880	2,590,967	0	4,008,553	31.00
43.00	04300	NURSERY	5,392	18,433	983,312	0	1,692,383	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	752,513	1,779,301	9,333,879	0	20,693,188	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	84,128	75,741	2,457,390	0	3,719,789	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	233,396	1,707,209	6,620,911	0	13,074,434	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	144,855	595,336	1,548,594	0	3,641,683	55.00
57.00	05700	CT SCAN	10,832	31,396	658,878	0	930,062	57.00
58.00	05800	MRI	209,701	447,652	1,972,844	0	3,737,930	58.00
59.00	05900	CARDIAC CATHETERIZATION	31,887	72,077	1,354,224	0	3,348,693	59.00
60.00	06000	LABORATORY	142,590	205,592	3,495,682	0	8,892,752	60.00
65.00	06500	RESPIRATORY THERAPY	2,057	32,334	1,255,254	0	1,771,737	65.00
66.00	06600	PHYSICAL THERAPY	190,529	7,859	2,217,789	0	3,192,471	66.00
68.00	06800	SPEECH PATHOLOGY	181,598	13,641	884,331	0	1,512,272	68.00
69.00	06900	ELECTROCARDIOLOGY	63,953	90,489	782,228	0	1,272,347	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	33,873	29,699	250,312	0	458,004	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	11,689,645	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	7,937,012	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	35,286,619	73.00
76.97	07697	CARDIAC REHABILITATION	9,215	8,647	643,354	0	889,494	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	95,126	3,564	1,324,244	0	2,198,714	90.01
90.02	09002	WOUND CLINIC	13,334	8,275	480,478	0	1,494,766	90.02
91.00	09100	EMERGENCY	227,556	108,547	6,045,469	0	9,019,903	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	49,019	12,288	785,032	0	1,178,996	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	555	6,354	3,052,223	0	3,633,455	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,124,382	5,927,823	92,525,520	-110,654,430	211,110,380	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,890	552	143,310	0	67,863	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,247,240	10,660	401,668	-4,447,343	0	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	16,268,012	9,886,946	1,975,912		110,654,430	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.734235	1.664739	0.021230		0.523986	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			207,890		11,705,449	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002234		0.055429	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet B-1 | Date/Time Prepared: 1/31/2019 1:20 am

	Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
		BLDG & FIXT (DV SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00	4.00	5A	5.00	
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet B-1 | Date/Time Prepared: 1/31/2019 1:20 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			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	330,047					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,164,923				8.00
9.00	00900	HOUSEKEEPING	6,918	614,405	4,352,197			9.00
10.00	01000	DIETARY	3,402	0	68,575	81,183		10.00
11.00	01100	CAFETERIA	12,035	0	18,287	0	1,934,023	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	1,433	0	9,143	0	1,182	12.00
13.00	01300	NURSING ADMINISTRATION	16,264	0	0	0	107,974	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,014	0	45,716	0	40,397	14.00
15.00	01500	PHARMACY	10,729	0	27,430	0	57,788	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,101	0	100,576	0	25,297	16.00
17.00	01700	SOCIAL SERVICE	6,629	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	3,478	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	42,808	336,037	2,569,258	56,436	358,406	30.00
31.00	03100	INTENSIVE CARE UNIT	7,696	37,201	205,724	7,740	61,520	31.00
43.00	04300	NURSERY	911	85,277	64,003	0	18,930	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	61,750	20,993	475,450	0	246,703	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,214	25,340	0	0	61,628	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,523	0	109,719	0	193,136	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	9,732	0	0	0	24,808	55.00
57.00	05700	CT SCAN	1,830	0	0	0	22,069	57.00
58.00	05800	MRI	8,026	0	0	0	55,263	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,388	0	0	0	30,525	59.00
60.00	06000	LABORATORY	15,231	0	137,149	0	118,015	60.00
65.00	06500	RESPIRATORY THERAPY	348	0	41,145	0	30,382	65.00
66.00	06600	PHYSICAL THERAPY	21,481	5,208	50,288	0	86,409	66.00
68.00	06800	SPEECH PATHOLOGY	9,329	0	0	0	26,612	68.00
69.00	06900	ELECTROCARDIOLOGY	2,846	0	0	0	19,777	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,723	0	0	0	6,374	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	1,557	2,530	0	0	16,146	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	6,474	0	214,867	0	39,816	90.01
90.02	09002	WOUND CLINIC	2,253	37,932	0	0	12,631	90.02
91.00	09100	EMERGENCY	22,857	0	178,294	0	140,469	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	2,461	0	0	17,007	44,710	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	84	0	0	0	73,776	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	330,047	1,164,923	4,315,624	81,183	1,924,221	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	36,573	0	2,895	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	6,907	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0	194.01
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)	28,304,567	1,346,218	7,896,800	3,584,801	5,042,633	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	85.759201	1.155628	1.814440	44.157040	2.607328	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	6,022,499	122,303	638,524	396,816	411,392	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	18.247398	0.104988	0.146713	4.887920	0.212713	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: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet B-1 | Date/Time Prepared: 1/31/2019 1:20 am

		Cost Center Description	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
			12.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL	1,012,080					12.00
13.00	01300	NURSING ADMINISTRATION	0	738,301				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	25,267,905			14.00
15.00	01500	PHARMACY	0	0	0	35,286,620		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	1,503,797,372	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	228,192	58,810	24,851	78,552,425	30.00
31.00	03100	INTENSIVE CARE UNIT	0	52,651	43,275	11,545	14,730,264	31.00
43.00	04300	NURSERY	0	23,310	3,408	107	8,180,356	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	153,931	2,383,472	95,720	230,762,271	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	44,780	45,390	13,008	25,731,311	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,540	721,304	8,418	141,326,392	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	9,983	1,041	1,014	37,269,675	55.00
57.00	05700	CT SCAN	0	831	98,753	1,200	65,987,896	57.00
58.00	05800	MRI	0	616	196,119	1,805	89,335,854	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	15,560	300,701	2,100	37,658,573	59.00
60.00	06000	LABORATORY	253,020	0	1,458,992	15,280	162,390,169	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	70,060	392	29,207,796	65.00
66.00	06600	PHYSICAL THERAPY	253,020	0	38	0	20,208,124	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	921	0	4,401,026	68.00
69.00	06900	ELECTROCARDIOLOGY	0	33	489	677	42,588,868	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	4,064	0	2,726,365	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	11,689,645	1,246	64,392,424	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	7,937,012	0	37,431,936	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	35,060,968	230,100,794	73.00
76.97	07697	CARDIAC REHABILITATION	0	8,683	55	33	2,202,699	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	0	25,813	2,058	9,867	12,088,718	90.01
90.02	09002	WOUND CLINIC	0	7,707	109,857	1,969	5,903,790	90.02
91.00	09100	EMERGENCY	506,040	107,660	62,148	34,378	149,604,278	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0	16,080	691	2,038	6,687,174	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	31,897	56,729	0	4,328,194	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,012,080	735,267	25,245,032	35,286,616	1,503,797,372	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,034	12	4	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	22,861	0	0	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0	194.01
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)	462,822	14,368,810	5,506,253	7,081,724	2,074,384	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.457298	19.461994	0.217915	0.200691	0.001379	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	206,713	850,974	737,389	673,109	204,595	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.204246	1.152611	0.029183	0.019075	0.000136	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: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet B-1 | Date/Time Prepared: 1/31/2019 1:20 am

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
			17.00	21.00	22.00		
		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
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	100				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	100			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0		100		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	100	100	100		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
43.00	04300	NURSERY	0	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		44.00
45.00	04500	NURSING FACILITY	0	0	0		45.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OP PEDS ONC CLINIC	0	0	0		90.01
90.02	09002	WOUND CLINIC	0	0	0		90.02
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0	0	0		92.01
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	100	100		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	0		194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0		194.01
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)	568,498	2,593,004	1,533,278		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5,684.980000	25,930.040000	15,332.780000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	120,962	94,310	107,697		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1,209.620000	943.100000	1,076.970000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet B-1 | Date/Time Prepared: 1/31/2019 1:20 am

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
			17.00	21.00	22.00		
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet C Part I Date/Time Prepared: 1/31/2019 1:20 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	44,514,970		44,514,970	0	44,514,970	30.00
31.00	03100	INTENSIVE CARE UNIT	8,744,178		8,744,178	0	8,744,178	31.00
43.00	04300	NURSERY	3,387,034		3,387,034	0	3,387,034	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	42,215,207		42,215,207	0	42,215,207	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,997,348		7,997,348	0	7,997,348	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,145,720		23,145,720	0	23,145,720	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,695,281		6,695,281	0	6,695,281	55.00
57.00	05700	CT SCAN	1,760,812		1,760,812	0	1,760,812	57.00
58.00	05800	MRI	6,707,227		6,707,227	0	6,707,227	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,065,729		6,065,729	0	6,065,729	59.00
60.00	06000	LABORATORY	16,075,826		16,075,826	0	16,075,826	60.00
65.00	06500	RESPIRATORY THERAPY	2,939,441	0	2,939,441	0	2,939,441	65.00
66.00	06600	PHYSICAL THERAPY	7,173,616	0	7,173,616	0	7,173,616	66.00
68.00	06800	SPEECH PATHOLOGY	3,180,385	0	3,180,385	0	3,180,385	68.00
69.00	06900	ELECTROCARDIOLOGY	2,294,290		2,294,290	0	2,294,290	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,210,057		1,210,057	0	1,210,057	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,451,248		20,451,248	0	20,451,248	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,877,108		13,877,108	0	13,877,108	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	61,130,049		61,130,049	0	61,130,049	73.00
76.97	07697	CARDIAC REHABILITATION	1,706,170		1,706,170	0	1,706,170	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	4,921,160		4,921,160	0	4,921,160	90.01
90.02	09002	WOUND CLINIC	2,730,454		2,730,454	0	2,730,454	90.02
91.00	09100	EMERGENCY	18,949,591		18,949,591	0	18,949,591	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	7,900,355		7,900,355		7,900,355	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	3,198,110		3,198,110	0	3,198,110	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	6,376,007		6,376,007		6,376,007	101.00
200.00		Subtotal (see instructions)	325,347,373	0	325,347,373	0	325,347,373	200.00
201.00		Less Observation Beds	7,900,355		7,900,355		7,900,355	201.00
202.00		Total (see instructions)	317,447,018	0	317,447,018	0	317,447,018	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet C Part I Date/Time Prepared: 1/31/2019 1:20 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	65,178,077		65,178,077			30.00
31.00	03100	INTENSIVE CARE UNIT	14,730,264		14,730,264			31.00
43.00	04300	NURSERY	8,180,356		8,180,356			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
45.00	04500	NURSING FACILITY	0		0			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	60,742,192	170,020,079	230,762,271	0.182938	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	24,009,732	1,721,579	25,731,311	0.310802	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,649,646	128,676,746	141,326,392	0.163775	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	445,636	36,824,039	37,269,675	0.179644	0.000000	55.00
57.00	05700	CT SCAN	20,035,036	45,952,860	65,987,896	0.026684	0.000000	57.00
58.00	05800	MRI	9,822,754	79,513,100	89,335,854	0.075079	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	18,688,983	18,969,590	37,658,573	0.161072	0.000000	59.00
60.00	06000	LABORATORY	60,789,212	101,600,957	162,390,169	0.098995	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	23,375,577	5,832,219	29,207,796	0.100639	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,970,876	14,237,248	20,208,124	0.354987	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	965,390	3,435,636	4,401,026	0.722646	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	12,413,772	30,175,096	42,588,868	0.053871	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	344,550	2,381,815	2,726,365	0.443835	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	26,937,503	37,454,921	64,392,424	0.317603	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,324,053	13,107,883	37,431,936	0.370729	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,702,568	206,398,226	230,100,794	0.265666	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	3,572	2,199,127	2,202,699	0.774582	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	572,727	11,515,991	12,088,718	0.407087	0.000000	90.01
90.02	09002	WOUND CLINIC	37,007	5,866,783	5,903,790	0.462492	0.000000	90.02
91.00	09100	EMERGENCY	23,800,975	125,803,303	149,604,278	0.126665	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,450,686	10,923,662	13,374,348	0.590710	0.000000	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	1,225,343	5,461,831	6,687,174	0.478245	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	4,328,194	4,328,194			101.00
200.00		Subtotal (see instructions)	441,396,487	1,062,400,885	1,503,797,372			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	441,396,487	1,062,400,885	1,503,797,372			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet C Part I Date/Time Prepared: 1/31/2019 1:20 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
45.00	04500	NURSING FACILITY		45.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.182938	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.310802	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.163775	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.179644	55.00
57.00	05700	CT SCAN	0.026684	57.00
58.00	05800	MRI	0.075079	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.161072	59.00
60.00	06000	LABORATORY	0.098995	60.00
65.00	06500	RESPIRATORY THERAPY	0.100639	65.00
66.00	06600	PHYSICAL THERAPY	0.354987	66.00
68.00	06800	SPEECH PATHOLOGY	0.722646	68.00
69.00	06900	ELECTROCARDIOLOGY	0.053871	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.443835	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.317603	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.370729	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.265666	73.00
76.97	07697	CARDIAC REHABILITATION	0.774582	76.97
		OUTPATIENT SERVICE COST CENTERS		
90.01	09001	OP PEDS ONC CLINIC	0.407087	90.01
90.02	09002	WOUND CLINIC	0.462492	90.02
91.00	09100	EMERGENCY	0.126665	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.590710	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0.478245	92.01
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet C Part I Date/Time Prepared: 1/31/2019 1:20 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	44,514,970		44,514,970	0	44,514,970	30.00
31.00	03100	INTENSIVE CARE UNIT	8,744,178		8,744,178	0	8,744,178	31.00
43.00	04300	NURSERY	3,387,034		3,387,034	0	3,387,034	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	42,215,207		42,215,207	0	42,215,207	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,997,348		7,997,348	0	7,997,348	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,145,720		23,145,720	0	23,145,720	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,695,281		6,695,281	0	6,695,281	55.00
57.00	05700	CT SCAN	1,760,812		1,760,812	0	1,760,812	57.00
58.00	05800	MRI	6,707,227		6,707,227	0	6,707,227	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,065,729		6,065,729	0	6,065,729	59.00
60.00	06000	LABORATORY	16,075,826		16,075,826	0	16,075,826	60.00
65.00	06500	RESPIRATORY THERAPY	2,939,441	0	2,939,441	0	2,939,441	65.00
66.00	06600	PHYSICAL THERAPY	7,173,616	0	7,173,616	0	7,173,616	66.00
68.00	06800	SPEECH PATHOLOGY	3,180,385	0	3,180,385	0	3,180,385	68.00
69.00	06900	ELECTROCARDIOLOGY	2,294,290		2,294,290	0	2,294,290	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,210,057		1,210,057	0	1,210,057	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,451,248		20,451,248	0	20,451,248	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,877,108		13,877,108	0	13,877,108	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	61,130,049		61,130,049	0	61,130,049	73.00
76.97	07697	CARDIAC REHABILITATION	1,706,170		1,706,170	0	1,706,170	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	4,921,160		4,921,160	0	4,921,160	90.01
90.02	09002	WOUND CLINIC	2,730,454		2,730,454	0	2,730,454	90.02
91.00	09100	EMERGENCY	18,949,591		18,949,591	0	18,949,591	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	7,900,355		7,900,355		7,900,355	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	3,198,110		3,198,110	0	3,198,110	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	6,376,007		6,376,007		6,376,007	101.00
200.00		Subtotal (see instructions)	325,347,373	0	325,347,373	0	325,347,373	200.00
201.00		Less Observation Beds	7,900,355		7,900,355		7,900,355	201.00
202.00		Total (see instructions)	317,447,018	0	317,447,018	0	317,447,018	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet C Part I Date/Time Prepared: 1/31/2019 1:20 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	65,178,077		65,178,077			30.00
31.00	03100	INTENSIVE CARE UNIT	14,730,264		14,730,264			31.00
43.00	04300	NURSERY	8,180,356		8,180,356			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
45.00	04500	NURSING FACILITY	0		0			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	60,742,192	170,020,079	230,762,271	0.182938	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	24,009,732	1,721,579	25,731,311	0.310802	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,649,646	128,676,746	141,326,392	0.163775	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	445,636	36,824,039	37,269,675	0.179644	0.000000	55.00
57.00	05700	CT SCAN	20,035,036	45,952,860	65,987,896	0.026684	0.000000	57.00
58.00	05800	MRI	9,822,754	79,513,100	89,335,854	0.075079	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	18,688,983	18,969,590	37,658,573	0.161072	0.000000	59.00
60.00	06000	LABORATORY	60,789,212	101,600,957	162,390,169	0.098995	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	23,375,577	5,832,219	29,207,796	0.100639	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,970,876	14,237,248	20,208,124	0.354987	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	965,390	3,435,636	4,401,026	0.722646	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	12,413,772	30,175,096	42,588,868	0.053871	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	344,550	2,381,815	2,726,365	0.443835	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	26,937,503	37,454,921	64,392,424	0.317603	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,324,053	13,107,883	37,431,936	0.370729	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,702,568	206,398,226	230,100,794	0.265666	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	3,572	2,199,127	2,202,699	0.774582	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	572,727	11,515,991	12,088,718	0.407087	0.000000	90.01
90.02	09002	WOUND CLINIC	37,007	5,866,783	5,903,790	0.462492	0.000000	90.02
91.00	09100	EMERGENCY	23,800,975	125,803,303	149,604,278	0.126665	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,450,686	10,923,662	13,374,348	0.590710	0.000000	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	1,225,343	5,461,831	6,687,174	0.478245	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	4,328,194	4,328,194			101.00
200.00		Subtotal (see instructions)	441,396,487	1,062,400,885	1,503,797,372			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	441,396,487	1,062,400,885	1,503,797,372			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet C Part I Date/Time Prepared: 1/31/2019 1:20 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
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
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.01	09001	OP PEDS ONC CLINIC	0.000000		90.01
90.02	09002	WOUND CLINIC	0.000000		90.02
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0.000000		92.01
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
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: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part I Date/Time Prepared: 1/31/2019 1:20 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,779,342	0	3,779,342	27,970	135.12	30.00
31.00	INTENSIVE CARE UNIT	694,250		694,250	3,033	228.90	31.00
43.00	NURSERY	209,577		209,577	4,503	46.54	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
45.00	NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (lines 30 through 199)	4,683,169		4,683,169	35,506		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	9,917	1,339,985	30.00
31.00	INTENSIVE CARE UNIT	1,573	360,060	31.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
45.00	NURSING FACILITY	0	0	45.00
200.00	Total (lines 30 through 199)	11,490	1,700,045	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part II Date/Time Prepared: 1/31/2019 1:20 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,999,628	230,762,271	0.030333	27,212,384	825,433	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	916,313	25,731,311	0.035611	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,921,743	141,326,392	0.034825	6,307,715	219,666	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,692,491	37,269,675	0.045412	199,085	9,041	55.00
57.00	05700	CT SCAN	187,981	65,987,896	0.002849	9,639,997	27,464	57.00
58.00	05800	MRI	1,510,311	89,335,854	0.016906	4,134,153	69,892	58.00
59.00	05900	CARDIAC CATHETERIZATION	538,828	37,658,573	0.014308	9,049,242	129,477	59.00
60.00	06000	LABORATORY	1,620,678	162,390,169	0.009980	27,161,383	271,071	60.00
65.00	06500	RESPIRATORY THERAPY	185,745	29,207,796	0.006359	12,085,894	76,854	65.00
66.00	06600	PHYSICAL THERAPY	1,058,201	20,208,124	0.052365	3,634,180	190,304	66.00
68.00	06800	SPEECH PATHOLOGY	599,960	4,401,026	0.136323	624,696	85,160	68.00
69.00	06900	ELECTROCARDIOLOGY	403,247	42,588,868	0.009468	6,529,673	61,823	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	246,084	2,726,365	0.090261	113,009	10,200	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	997,860	64,392,424	0.015497	11,538,111	178,806	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	676,658	37,431,936	0.018077	12,044,105	217,721	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,656,051	230,100,794	0.011543	9,255,073	106,831	73.00
76.97	07697	CARDIAC REHABILITATION	123,539	2,202,699	0.056085	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	516,040	12,088,718	0.042688	452,752	19,327	90.01
90.02	09002	WOUND CLINIC	182,232	5,903,790	0.030867	31,745	980	90.02
91.00	09100	EMERGENCY	1,949,326	149,604,278	0.013030	10,460,858	136,305	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	670,740	13,374,348	0.050151	1,505,655	75,510	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	336,894	6,687,174	0.050379	624,977	31,486	92.01
200.00		Total (lines 50 through 199)	28,990,550	1,411,380,481		152,604,687	2,743,351	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part III Date/Time Prepared: 1/31/2019 1:20 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
45.00	04500	NURSING FACILITY	0	0	0	0		45.00
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	27,970	0.00	9,917	30.00
31.00	03100	INTENSIVE CARE UNIT		0	3,033	0.00	1,573	31.00
43.00	04300	NURSERY		0	4,503	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
45.00	04500	NURSING FACILITY		0	0	0.00	0	45.00
200.00		Total (lines 30 through 199)		0	35,506		11,490	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
45.00	04500	NURSING FACILITY	0	45.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part IV | Date/Time Prepared: 1/31/2019 1:20 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	0	0	0	0	0	90.01
90.02	09002	WOUND CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0	0	0	0	0	92.01
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part IV Date/Time Prepared: 1/31/2019 1:20 am

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	230,762,271	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	25,731,311	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	141,326,392	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	37,269,675	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	65,987,896	0.000000	57.00
58.00	05800	MRI	0	0	0	89,335,854	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	37,658,573	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	162,390,169	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	29,207,796	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	20,208,124	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	4,401,026	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	42,588,868	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,726,365	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	64,392,424	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	37,431,936	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	230,100,794	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	2,202,699	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	0	0	0	12,088,718	0.000000	90.01
90.02	09002	WOUND CLINIC	0	0	0	5,903,790	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	149,604,278	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	13,374,348	0.000000	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0	0	0	6,687,174	0.000000	92.01
200.00		Total (lines 50 through 199)	0	0	0	1,411,380,481		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part IV Date/Time Prepared: 1/31/2019 1:20 am

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	27,212,384	0	35,109,499	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	6,307,715	0	32,900,466	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	199,085	0	14,652,865	0	55.00
57.00	05700	CT SCAN	0.000000	9,639,997	0	13,074,859	0	57.00
58.00	05800	MRI	0.000000	4,134,153	0	21,495,858	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	9,049,242	0	8,713,033	0	59.00
60.00	06000	LABORATORY	0.000000	27,161,383	0	18,697,236	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	12,085,894	0	1,322,087	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	3,634,180	0	454,035	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	624,696	0	261,188	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	6,529,673	0	10,064,268	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	113,009	0	742,109	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	11,538,111	0	8,929,539	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	12,044,105	0	3,093,482	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	9,255,073	0	78,067,407	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	690,390	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	0.000000	452,752	0	4,794,445	0	90.01
90.02	09002	WOUND CLINIC	0.000000	31,745	0	2,940,490	0	90.02
91.00	09100	EMERGENCY	0.000000	10,460,858	0	18,531,654	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,505,655	0	3,681,615	0	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0.000000	624,977	0	2,328,071	0	92.01
200.00		Total (lines 50 through 199)		152,604,687	0	280,544,596	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part V Date/Time Prepared: 1/31/2019 1:20 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.182938	35,109,499	0	0	6,422,862	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.310802	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.163775	32,900,466	0	0	5,388,274	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.179644	14,652,865	0	0	2,632,299	55.00
57.00	05700	CT SCAN	0.026684	13,074,859	0	0	348,890	57.00
58.00	05800	MRI	0.075079	21,495,858	0	0	1,613,888	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.161072	8,713,033	0	0	1,403,426	59.00
60.00	06000	LABORATORY	0.098995	18,697,236	0	0	1,850,933	60.00
65.00	06500	RESPIRATORY THERAPY	0.100639	1,322,087	0	0	133,054	65.00
66.00	06600	PHYSICAL THERAPY	0.354987	454,035	0	0	161,177	66.00
68.00	06800	SPEECH PATHOLOGY	0.722646	261,188	0	0	188,746	68.00
69.00	06900	ELECTROCARDIOLOGY	0.053871	10,064,268	0	0	542,172	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.443835	742,109	0	0	329,374	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.317603	8,929,539	0	0	2,836,048	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.370729	3,093,482	0	0	1,146,843	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.265666	78,067,407	0	0	20,739,856	73.00
76.97	07697	CARDIAC REHABILITATION	0.774582	690,390	0	0	534,764	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	0.407087	4,794,445	0	0	1,951,756	90.01
90.02	09002	WOUND CLINIC	0.462492	2,940,490	0	0	1,359,953	90.02
91.00	09100	EMERGENCY	0.126665	18,531,654	0	0	2,347,312	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.590710	3,681,615	0	0	2,174,767	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0.478245	2,328,071	0	0	1,113,388	92.01
200.00		Subtotal (see instructions)		280,544,596	0	0	55,219,782	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		280,544,596	0	0	55,219,782	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D Part V Date/Time Prepared: 1/31/2019 1:20 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.01	09001	OP PEDS ONC CLINIC	0	0		90.01
90.02	09002	WOUND CLINIC	0	0		90.02
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0	0		92.01
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D-1 | Date/Time Prepared: 1/31/2019 1:20 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	27,970	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	27,970	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)	23,006	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)	9,917	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)	44,514,970	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)	44,514,970	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)	44,514,970	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)	1,591.53	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	15,783,203	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)	15,783,203	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D-1 | Date/Time Prepared: 1/31/2019 1:20 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	8,744,178	3,033	2,883.01	1,573	4,534,975	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	27,421,491	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	47,739,669	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	1,700,045	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	2,743,351	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	4,443,396	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	43,296,273	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)	4,964	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,591.53	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	7,900,355	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D-1 | Date/Time Prepared: 1/31/2019 1:20 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	3,779,342	44,514,970	0.084900	7,900,355	670,740	90.00
91.00	Nursing School cost	0	44,514,970	0.000000	7,900,355	0	91.00
92.00	Allied health cost	0	44,514,970	0.000000	7,900,355	0	92.00
93.00	All other Medical Education	0	44,514,970	0.000000	7,900,355	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0130	Period: From 09/01/2017 To 08/31/2018	Worksheet D-1 Date/Time Prepared: 1/31/2019 1:20 am
	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)	27,970	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	27,970	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)	23,006	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)	924	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)	4,503	15.00
16.00	Nursery days (title V or XIX only)	857	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)	44,514,970	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)	44,514,970	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)	44,514,970	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)	1,591.53	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,470,574	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,470,574	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D-1 | Date/Time Prepared: 1/31/2019 1:20 am

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)	3,387,034	4,503	752.17	857	644,610	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	8,744,178	3,033	2,883.01	678	1,954,681	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,069,865	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)	4,964	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,591.53	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	7,900,355	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D-1 | Date/Time Prepared: 1/31/2019 1:20 am

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	3,779,342	44,514,970	0.084900	7,900,355	670,740	90.00
91.00	Nursing School cost	0	44,514,970	0.000000	7,900,355	0	91.00
92.00	Allied health cost	0	44,514,970	0.000000	7,900,355	0	92.00
93.00	All other Medical Education	0	44,514,970	0.000000	7,900,355	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet D-3 | Date/Time Prepared: 1/31/2019 1:20 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		27,749,518		30.00
31.00	03100	INTENSIVE CARE UNIT		7,176,078		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.182938	27,212,384	4,978,179	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.310802	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.163775	6,307,715	1,033,046	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.179644	199,085	35,764	55.00
57.00	05700	CT SCAN	0.026684	9,639,997	257,234	57.00
58.00	05800	MRI	0.075079	4,134,153	310,388	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.161072	9,049,242	1,457,580	59.00
60.00	06000	LABORATORY	0.098995	27,161,383	2,688,841	60.00
65.00	06500	RESPIRATORY THERAPY	0.100639	12,085,894	1,216,312	65.00
66.00	06600	PHYSICAL THERAPY	0.354987	3,634,180	1,290,087	66.00
68.00	06800	SPEECH PATHOLOGY	0.722646	624,696	451,434	68.00
69.00	06900	ELECTROCARDIOLOGY	0.053871	6,529,673	351,760	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.443835	113,009	50,157	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.317603	11,538,111	3,664,539	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.370729	12,044,105	4,465,099	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.265666	9,255,073	2,458,758	73.00
76.97	07697	CARDIAC REHABILITATION	0.774582	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.01	09001	OP PEDS ONC CLINIC	0.407087	452,752	184,309	90.01
90.02	09002	WOUND CLINIC	0.462492	31,745	14,682	90.02
91.00	09100	EMERGENCY	0.126665	10,460,858	1,325,025	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.590710	1,505,655	889,405	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0.478245	624,977	298,892	92.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		152,604,687	27,421,491	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)		152,604,687		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0130	Period: From 09/01/2017 To 08/31/2018	Worksheet E Part A Date/Time Prepared: 1/31/2019 1:20 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	2,234,422	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	24,578,640	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	1,265,505	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	2,824,967	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	108.20	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	23.71	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	23.71	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.219131	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.214473	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.214473	21.00
22.00	IME payment adjustment (see instructions)	2,963,675	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	312,246	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	2,963,675	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	312,246	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	1.88	30.00
31.00	Percentage of Medicaid patient days (see instructions)	14.83	31.00
32.00	Sum of lines 30 and 31	16.71	32.00
33.00	Allowable disproportionate share percentage (see instructions)	3.62	33.00
34.00	Disproportionate share adjustment (see instructions)	242,659	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0130	Period: From 09/01/2017 To 08/31/2018	Worksheet E Part A Date/Time Prepared: 1/31/2019 1:20 am
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	5,977,483,147	6,766,695,164	35.00
35.01	Factor 3 (see instructions)	0.000057595	0.000166160	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	344,273	1,124,354	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	28,296	1,031,941	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,060,237		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)	32,345,138		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)		32,657,384	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,519,520	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).		510,417	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		1,036	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		35,688,357	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		35,688,357	61.00
62.00	Deductibles billed to program beneficiaries		67,041	62.00
63.00	Coinsurance billed to program beneficiaries		2,900,020	63.00
64.00	Allowable bad debts (see instructions)		207,413	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		134,818	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		161,248	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		32,856,114	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)		198,613	70.93
70.94	HRR adjustment amount (see instructions)		-788,362	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0130	Period: From 09/01/2017 To 08/31/2018	Worksheet E Part A Date/Time Prepared: 1/31/2019 1:20 am
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		345,882	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		31,920,483	71.00
71.01	Sequestration adjustment (see instructions)		638,410	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		29,523,116	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)		1,758,957	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		2,978,399	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)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 1/31/2019 1:20 am

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,234,422	0	2,235,972		2,235,972	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	24,578,640	0		26,831,663	26,831,663	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	1,265,505	0	0	1,265,505	1,265,505	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	2,824,967	0	0	2,824,967	2,824,967	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.214473	0.214473	0.214473	0.214473		5.00
6.00	IME payment adjustment (see instructions)	22.00	2,963,675	0	247,144	2,716,531	2,963,675	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	312,246	0	0	312,246	312,246	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	2,963,675	0	247,144	2,716,531	2,963,675	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	312,246	0	0	312,246	312,246	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0362	0.0362	0.0362	0.0362		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	242,659	0	20,236	222,423	242,659	11.00
11.01	Uncompensated care payments	36.00	1,060,237	0	28,296	1,031,941	1,060,237	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	32,345,138	0	2,531,648	29,813,490	32,345,138	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	32,657,384	0	2,531,648	30,125,736	32,657,384	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,519,520	0	0	2,519,520	2,519,520	16.00
17.00	Special add-on payments for new technologies	54.00	1,036	0	0	1,036	1,036	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: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 1/31/2019 1:20 am

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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	2,531,648	32,646,292	35,177,940	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	2,182,836	0	0	2,182,836	2,182,836	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	62,083	0	0	62,083	62,083	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	0.0914	0.0914	0.0914	0.0914		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	199,511	0	0	199,511	199,511	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0344	0.0344	0.0344	0.0344		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	75,090	0	0	75,090	75,090	25.00
26.00	Total prospective capital payments (see instructions)	12.00	2,519,520	0	0	2,519,520	2,519,520	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 1/31/2019 1:20 am

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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	2,234,422	2,234,422		2,234,422	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	24,578,640		24,578,640	24,578,640	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	1,265,505	0	1,265,505	1,265,505	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	2,824,967	0	2,824,967	2,824,967	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.214473	0.214473	0.214473		5.00
6.00	IME payment adjustment (see instructions)	22.00	2,963,675	246,973	2,716,702	2,963,675	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	312,246	0	312,246	312,246	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	2,963,675	246,973	2,716,702	2,963,675	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	312,246	0	312,246	312,246	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0362	0.0362	0.0362		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	242,659	20,222	222,437	242,659	11.00
11.01	Uncompensated care payments	36.00	1,060,237	28,296	1,031,941	1,060,237	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	32,345,138	2,529,913	29,815,225	32,345,138	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	32,657,384	2,529,913	30,127,471	32,657,384	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,519,520	0	2,519,520	2,519,520	16.00
17.00	Special add-on payments for new technologies	54.00	1,036	0	1,036	1,036	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			2,529,913	32,648,027	35,177,940	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 1/31/2019 1:20 am

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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	2,182,836	0	2,182,836	2,182,836	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	62,083	0	62,083	62,083	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	0.0914	0.0914	0.0914		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	199,511	0	199,511	199,511	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0344	0.0344	0.0344		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	75,090	0	75,090	75,090	25.00
26.00	Total prospective capital payments (see instructions)	12.00	2,519,520	0	2,519,520	2,519,520	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	198,613	0	198,613	198,613	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	-788,362	0	-788,362	-788,362	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		25,299	320,583	345,882	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0130	Period: From 09/01/2017 To 08/31/2018	Worksheet E Part B Date/Time Prepared: 1/31/2019 1:20 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	55,219,782	2.00
3.00	OPPS payments	35,889,713	3.00
4.00	Outlier payment (see instructions)	800,235	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	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)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	36,689,948	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)	6,731,772	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)	29,958,176	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	590,394	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)	30,548,570	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	30,548,570	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)	527,723	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	343,020	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	430,718	36.00
37.00	Subtotal (see instructions)	30,891,590	37.00
38.00	MSP-LCC reconciliation amount from PS&R	75	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)	30,891,515	40.00
40.01	Sequestration adjustment (see instructions)	617,830	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	29,917,062	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	356,623	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	501,477	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet E-1 Part I Date/Time Prepared: 1/31/2019 1:20 am

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		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		27,333,113		29,347,604	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		298,171		290,786	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	03/22/2018	166,605	03/22/2018	154,481	3.01
3.02		08/27/2018	1,725,227	08/27/2018	124,191	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
3.06			0		0	3.06
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		1,891,832		278,672	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)		29,523,116		29,917,062	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		1,758,957		356,623	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		31,282,073		30,273,685	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: 14-0130	Period: From 09/01/2017 To 08/31/2018	Worksheet E-1 Part II Date/Time Prepared: 1/31/2019 1:20 am
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0130	Period: From 09/01/2017 To 08/31/2018	Worksheet E-3 Part VII Date/Time Prepared: 1/31/2019 1:20 am
	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	4,069,865		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	4,069,865	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	4,069,865	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
	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)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	4,069,865	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	4,069,865	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet E-4 | Date/Time Prepared: 1/31/2019 1:20 am

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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.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts			0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.00	6.00
7.00	Enter the lesser of line 5 or line 6			0.00	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	0.00	0.00	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	0.00	0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	23.71	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	23.71	0.00		17.00
18.00	Per resident amount	103,056.05	0.00		18.00
19.00	Approved amount for resident costs	2,443,459	0	2,443,459	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			2,443,459	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions)	11,490	1,269		26.00
27.00	Total Inpatient Days (see instructions)	27,923	27,923		27.00
28.00	Ratio of inpatient days to total inpatient days	0.411489	0.045446		28.00
29.00	Program direct GME amount	1,005,457	111,045		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		15,691		30.00
31.00	Net Program direct GME amount			1,100,811	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 14-0130	Period: From 09/01/2017 To 08/31/2018	Worksheet E-4 Date/Time Prepared: 1/31/2019 1:20 am
	Title XVIII	Hospital	PPS

		1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)		
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)	0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)	0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)	0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)	0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)	0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY		
	Part A Reasonable Cost		
37.00	Reasonable cost (see instructions)	47,739,669	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)	47,739,669	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	55,219,782	42.00
43.00	Primary payer payments (see instructions)	0	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	55,219,782	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	102,959,451	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.463674	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.536326	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	1,100,811	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	510,417	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	590,394	50.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet G | Date/Time Prepared: 1/31/2019 1:20 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,205,025	25,455,299	30,638,583	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	-1,587,427	0	0	0	3.00
4.00	Accounts receivable	63,393,746	0	0	0	4.00
5.00	Other receivable	1,740,435	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-23,619,215	0	0	0	6.00
7.00	Inventory	6,229,737	0	0	0	7.00
8.00	Prepaid expenses	673,641	0	0	0	8.00
9.00	Other current assets	8,521,039	0	0	0	9.00
10.00	Due from other funds	1,017,616	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	57,574,597	25,455,299	30,638,583	0	11.00
	FIXED ASSETS					
12.00	Land	52,023,598	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	548,513,146	0	0	0	15.00
16.00	Accumulated depreciation	-105,214,248	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	106,606,550	0	0	0	19.00
20.00	Accumulated depreciation	-37,958,375	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	563,970,671	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	60,465,301	5,669,511	8,943	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	6,504,959	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	66,970,260	5,669,511	8,943	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	688,515,528	31,124,810	30,647,526	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	8,103,212	0	0	0	37.00
38.00	Salaries, wages, and fees payable	11,331,502	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	49,579,837	0	0	0	43.00
44.00	Other current liabilities	8,926,408	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	77,940,959	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	30,669,991	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	30,669,991	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	108,610,950	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	579,904,578				52.00
53.00	Specific purpose fund		31,124,810			53.00
54.00	Donor created - endowment fund balance - restricted			30,647,526		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)	579,904,578	31,124,810	30,647,526	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	688,515,528	31,124,810	30,647,526	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet G-1 | Date/Time Prepared: 1/31/2019 1:20 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		446,143,843		25,455,299		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-20,807,382				2.00
3.00	Total (sum of line 1 and line 2)		425,336,461		25,455,299		3.00
4.00	ASSET RELEA TO FINANCE PROP AND EQUI	4,873,208		0		0	4.00
5.00	TRANSFERS	20,100		301		0	5.00
6.00	POST BENE TO RELATED TO NET PENSION	8,138,752		0		0	6.00
7.00	GIFTS AND OTHER REVENUE	0		9,526,176		8,943	7.00
8.00	INTERCOMPANY SETTLEMENTS	141,545,400		24,282		0	8.00
9.00	INVESTMENT INCOM & CHG IN NET ASSETS	0		2,786,611		0	9.00
10.00	Total additions (sum of line 4-9)		154,577,460		12,337,370		10.00
11.00	Subtotal (line 3 plus line 10)		579,913,921		37,792,669		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	OPERATING EXPENSES	0		1,765,084		0	13.00
14.00	PROPERTY ADDITIONS	0		4,873,208		0	14.00
15.00	RECLASSIFICATION	0		20,100		0	15.00
16.00	OTHER	9,343		9,467		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		9,343		6,667,859		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		579,904,578		31,124,810		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	30,638,583		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)	30,638,583		0		3.00
4.00	ASSET RELEA TO FINANCE PROP AND EQUI		0			4.00
5.00	TRANSFERS		0			5.00
6.00	POST BENE TO RELATED TO NET PENSION		0			6.00
7.00	GIFTS AND OTHER REVENUE		0			7.00
8.00	INTERCOMPANY SETTLEMENTS		0			8.00
9.00	INVESTMENT INCOM & CHG IN NET ASSETS		0			9.00
10.00	Total additions (sum of line 4-9)	8,943		0		10.00
11.00	Subtotal (line 3 plus line 10)	30,647,526		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00	OPERATING EXPENSES		0			13.00
14.00	PROPERTY ADDITIONS		0			14.00
15.00	RECLASSIFICATION		0			15.00
16.00	OTHER		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)	30,647,526		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 1/31/2019 1:20 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	77,288,929		77,288,929	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	0		0	7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	77,288,929		77,288,929	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	14,532,252		14,532,252	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	14,532,252		14,532,252	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	91,821,181		91,821,181	17.00
18.00	Ancillary services	347,204,679	0	347,204,679	18.00
19.00	Outpatient services	0	1,058,121,664	1,058,121,664	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		4,328,194	4,328,194	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	439,025,860	1,062,449,858	1,501,475,718	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		343,309,236		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	BAD DEBT	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)		343,309,236		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-0130 | Period: From 09/01/2017 To 08/31/2018 | Worksheet G-3 | Date/Time Prepared: 1/31/2019 1:20 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,501,475,718	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,197,770,340	2.00
3.00	Net patient revenues (line 1 minus line 2)	303,705,378	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	343,309,236	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-39,603,858	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,384,602	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	1,113,107	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	16,396	21.00
22.00	Rental of hospital space	6,401,415	22.00
23.00	Governmental appropriations	6,206,680	23.00
24.00	NET ASSETS	1,754,082	24.00
24.01	OTHER INCOME	1,920,194	24.01
25.00	Total other income (sum of lines 6-24)	18,796,476	25.00
26.00	Total (line 5 plus line 25)	-20,807,382	26.00
27.00	OTHER	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)	-20,807,382	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0130 HHA CCN: 14-7045 | Period: From 09/01/2017 To 08/31/2018 | Worksheet H | Date/Time Prepared: 1/31/2019 1:20 am

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	599,904	0	0	0	212,711	812,615	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	1,551,766	0	0	0	550,218	2,101,984	6.00
7.00	Physical Therapy	607,498	0	0	0	215,404	822,902	7.00
8.00	Occupational Therapy	149,414	0	0	0	52,978	202,392	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	45,537	0	0	0	16,146	61,683	10.00
11.00	Home Health Aide	72,596	0	0	0	25,741	98,337	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	3,026,715	0	0	0	1,073,198	4,099,913	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	812,615	-107,584	705,031			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	2,101,984	-278,287	1,823,697			6.00
7.00	Physical Therapy	0	822,902	-108,946	713,956			7.00
8.00	Occupational Therapy	0	202,392	-26,795	175,597			8.00
9.00	Speech Pathology	0	0	0	0			9.00
10.00	Medical Social Services	0	61,683	-8,167	53,516			10.00
11.00	Home Health Aide	0	98,337	-13,019	85,318			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	0	4,099,913	-542,798	3,557,115			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 14-0130 HHA CCN: 14-7045 | Period: From 09/01/2017 To 08/31/2018 | Worksheet H-1 Part I Date/Time Prepared: 1/31/2019 1:20 am

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	705,031	0	0	0	0	705,031	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	1,823,697	0	0	0	0	1,823,697	6.00
7.00	Physical Therapy	713,956	0	0	0	0	713,956	7.00
8.00	Occupational Therapy	175,597	0	0	0	0	175,597	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	53,516	0	0	0	0	53,516	10.00
11.00	Home Health Aide	85,318	0	0	0	0	85,318	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	3,557,115	0	0	0	0	3,557,115	24.00

		Administrative & General	Total (cols. 4A + 5)		
		5.00	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related - Bldg. & Fixtures				1.00
2.00	Capital Related - Movable Equipment				2.00
3.00	Plant Operation & Maintenance				3.00
4.00	Transportation				4.00
5.00	Administrative and General	705,031			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	439,106	2,262,803		6.00
7.00	Physical Therapy	190,395	904,351		7.00
8.00	Occupational Therapy	39,656	215,253		8.00
9.00	Speech Pathology	0	0		9.00
10.00	Medical Social Services	13,236	66,752		10.00
11.00	Home Health Aide	22,638	107,956		11.00
12.00	Supplies (see instructions)	0	0		12.00
13.00	Drugs	0	0		13.00
14.00	DME	0	0		14.00
	HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0		15.00
16.00	Respiratory Therapy	0	0		16.00
17.00	Private Duty Nursing	0	0		17.00
18.00	Clinic	0	0		18.00
19.00	Health Promotion Activities	0	0		19.00
20.00	Day Care Program	0	0		20.00
21.00	Home Delivered Meals Program	0	0		21.00
22.00	Homemaker Service	0	0		22.00
23.00	All Others (specify)	0	0		23.00
23.50	Telemedicine	0	0		23.50
24.00	Total (sum of lines 1-23)		3,557,115		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 14-0130 HHA CCN: 14-7045 | Period: From 09/01/2017 To 08/31/2018 | Worksheet H-1 Part II Date/Time Prepared: 1/31/2019 1:20 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-705,031	1,512,844	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	-881,469	942,228	6.00
7.00	Physical Therapy	0	0	0	0	-305,410	408,546	7.00
8.00	Occupational Therapy	0	0	0	0	-90,504	85,093	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	-25,115	28,401	10.00
11.00	Home Health Aide	0	0	0	0	-36,742	48,576	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-2,044,271	1,512,844	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		705,031	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.466030	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0130 | HHA CCN: 14-7045 | Period: From 09/01/2017 To 08/31/2018 | Worksheet H-2 Part I | Date/Time Prepared: 1/31/2019 1:20 am

Home Health Agency I | PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	191	10,578	12,843	23,612	3,836	1.00
2.00	Skilled Nursing Care	2,262,803	494	0	33,222	2,296,519	1,184,646	2.00
3.00	Physical Therapy	904,351	193	0	13,006	917,550	512,207	3.00
4.00	Occupational Therapy	215,253	47	0	3,199	218,499	106,684	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	66,752	14	0	975	67,741	35,606	6.00
7.00	Home Health Aide	107,956	24	0	1,554	109,534	60,901	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	3,557,115	963	10,578	64,799	3,633,455	1,903,880	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	
		7.00	8.00	9.00	10.00	11.00	12.00	
1.00	Administrative and General	1,372	0	0	0	38,127	0	1.00
2.00	Skilled Nursing Care	3,687	0	0	0	98,620	0	2.00
3.00	Physical Therapy	1,544	0	0	0	38,609	0	3.00
4.00	Occupational Therapy	343	0	0	0	9,493	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	86	0	0	0	2,894	0	6.00
7.00	Home Health Aide	172	0	0	0	4,615	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	7,204	0	0	0	192,358	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0130 | HHA CCN: 14-7045 | Period: From 09/01/2017 To 08/31/2018 | Worksheet H-2 Part I | Date/Time Prepared: 1/31/2019 1:20 am

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	Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	
		13.00	14.00	15.00	16.00	17.00	21.00	
1.00	Administrative and General	123,039	2,450	0	1,183	0	0	1.00
2.00	Skilled Nursing Care	318,261	6,338	0	3,060	0	0	2.00
3.00	Physical Therapy	124,596	2,481	0	1,198	0	0	3.00
4.00	Occupational Therapy	30,653	610	0	295	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	9,342	186	0	90	0	0	6.00
7.00	Home Health Aide	14,888	297	0	143	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	620,779	12,362	0	5,969	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		22.00	24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	0	193,619	0	193,619			1.00
2.00	Skilled Nursing Care	0	3,911,131	0	3,911,131	122,488	4,033,619	2.00
3.00	Physical Therapy	0	1,598,185	0	1,598,185	50,052	1,648,237	3.00
4.00	Occupational Therapy	0	366,577	0	366,577	11,480	378,057	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	115,945	0	115,945	3,631	119,576	6.00
7.00	Home Health Aide	0	190,550	0	190,550	5,968	196,518	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	6,376,007	0	6,376,007	193,619	6,376,007	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.031318		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0130 HHA CCN: 14-7045

Period: From 09/01/2017 To 08/31/2018

Worksheet H-2 Part II Date/Time Prepared: 1/31/2019 1:20 am

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (DV SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	110	6,354	604,960	-19,841	3,771	16	1.00
2.00	Skilled Nursing Care	285	0	1,564,844	-1,131,990	1,164,529	43	2.00
3.00	Physical Therapy	111	0	612,618	-414,041	503,509	18	3.00
4.00	Occupational Therapy	27	0	150,673	-113,627	104,872	4	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	8	0	45,920	-32,740	35,001	1	6.00
7.00	Home Health Aide	14	0	73,208	-49,667	59,867	2	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	555	6,354	3,052,223		1,871,549	84	20.00
21.00	Total cost to be allocated	963	10,578	64,799		1,903,880	7,204	21.00
22.00	Unit cost multiplier	1.735135	1.664778	0.021230		1.017275	85.761905	22.00

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
		8.00	9.00	10.00	11.00	12.00	13.00	
1.00	Administrative and General	0	0	0	14,623	0	6,322	1.00
2.00	Skilled Nursing Care	0	0	0	37,824	0	16,353	2.00
3.00	Physical Therapy	0	0	0	14,808	0	6,402	3.00
4.00	Occupational Therapy	0	0	0	3,641	0	1,575	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	1,110	0	480	6.00
7.00	Home Health Aide	0	0	0	1,770	0	765	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	73,776	0	31,897	20.00
21.00	Total cost to be allocated	0	0	0	192,358	0	620,779	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	2.607325	0.000000	19.461987	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0130
HHA CCN: 14-7045

Period: From 09/01/2017 To 08/31/2018

Worksheet H-2 Part II
Date/Time Prepared: 1/31/2019 1:20 am

Home Health Agency I

PPS

	Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	
		14.00	15.00	16.00	17.00	21.00	22.00	
1.00	Administrative and General	11,244	0	857,862	0	0	0	1.00
2.00	Skilled Nursing Care	29,084	0	2,219,021	0	0	0	2.00
3.00	Physical Therapy	11,386	0	868,721	0	0	0	3.00
4.00	Occupational Therapy	2,800	0	213,661	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	854	0	65,117	0	0	0	6.00
7.00	Home Health Aide	1,361	0	103,812	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	56,729	0	4,328,194	0	0	0	20.00
21.00	Total cost to be allocated	12,362	0	5,969	0	0	0	21.00
22.00	Unit cost multiplier	0.217913	0.000000	0.001379	0.000000	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 14-0130 HHA CCN: 14-7045 | Period: From 09/01/2017 To 08/31/2018 | Worksheet H-3 Part I Date/Time Prepared: 1/31/2019 1:20 am

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	4,033,619		4,033,619	6,161	654.70	1.00
2.00	Physical Therapy	3.00	1,648,237	0	1,648,237	3,421	481.80	2.00
3.00	Occupational Therapy	4.00	378,057	0	378,057	903	418.67	3.00
4.00	Speech Pathology	5.00	0	0	0	0	0.00	4.00
5.00	Medical Social Services	6.00	119,576		119,576	224	533.82	5.00
6.00	Home Health Aide	7.00	196,518		196,518	462	425.36	6.00
7.00	Total (sum of lines 1-6)		6,376,007	0	6,376,007	11,171		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		16974	0	1,090			8.00
8.01	Skilled Nursing Care		29404	0	5,071			8.01
9.00	Physical Therapy		16974	0	615			9.00
9.01	Physical Therapy		29404	0	2,806			9.01
10.00	Occupational Therapy		16974	0	168			10.00
10.01	Occupational Therapy		29404	0	735			10.01
11.00	Speech Pathology		16974	0	0			11.00
11.01	Speech Pathology		29404	0	0			11.01
12.00	Medical Social Services		16974	0	24			12.00
12.01	Medical Social Services		29404	0	200			12.01
13.00	Home Health Aide		16974	0	47			13.00
13.01	Home Health Aide		29404	0	415			13.01
14.00	Total (sum of lines 8-13)			0	11,171			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	6,161		0	4,033,607		1.00
2.00	Physical Therapy	0	3,421		0	1,648,238		2.00
3.00	Occupational Therapy	0	903		0	378,059		3.00
4.00	Speech Pathology	0	0		0	0		4.00
5.00	Medical Social Services	0	224		0	119,576		5.00
6.00	Home Health Aide	0	462		0	196,516		6.00
7.00	Total (sum of lines 1-6)	0	11,171		0	6,375,996		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 14-0130 HHA CCN: 14-7045 | Period: From 09/01/2017 To 08/31/2018 | Worksheet H-3 Part I Date/Time Prepared: 1/31/2019 1:20 am

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	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00

	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)		
		12.00		
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION			
	Cost Per Visit Computation			
1.00	Skilled Nursing Care	4,033,607		1.00
2.00	Physical Therapy	1,648,238		2.00
3.00	Occupational Therapy	378,059		3.00
4.00	Speech Pathology	0		4.00
5.00	Medical Social Services	119,576		5.00
6.00	Home Health Aide	196,516		6.00
7.00	Total (sum of lines 1-6)	6,375,996		7.00

	Cost Center Description		
		12.00	
	Limitation Cost Computation		
8.00	Skilled Nursing Care		8.00
8.01	Skilled Nursing Care		8.01
9.00	Physical Therapy		9.00
9.01	Physical Therapy		9.01
10.00	Occupational Therapy		10.00
10.01	Occupational Therapy		10.01
11.00	Speech Pathology		11.00
11.01	Speech Pathology		11.01
12.00	Medical Social Services		12.00
12.01	Medical Social Services		12.01
13.00	Home Health Aide		13.00
13.01	Home Health Aide		13.01
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0130 HHA CCN: 14-7045 | Period: From 09/01/2017 To 08/31/2018 | Worksheet H-3 Part II Date/Time Prepared: 1/31/2019 1:20 am

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.354987	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy							2.00
3.00	Speech Pathology	68.00	0.722646	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.317603	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.265666	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0130 | HHA CCN: 14-7045 | Period: From 09/01/2017 To 08/31/2018 | Worksheet H-4 Part I-II | Date/Time Prepared: 1/31/2019 1:20 am

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	1,871,003	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	152,053	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	39,300	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	41,279	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	39,561	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	2,143,196	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	2,143,196	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	2,143,196	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	2,143,196	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	2,143,196	31.00
31.01	Sequestration adjustment (see instructions)	0	0	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	2,143,196	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

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

Provider CCN: 14-0130 | HHA CCN: 14-7045 | Period: From 09/01/2017 To 08/31/2018 | Worksheet H-5 | Date/Time Prepared: 1/31/2019 1:20 am

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		2,143,196	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		2,143,196	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		2,143,196	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0130	Period: From 09/01/2017 To 08/31/2018	Worksheet L Parts I-III Date/Time Prepared: 1/31/2019 1:20 am
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		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	2,182,836	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	62,083	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)	76.50	3.00
4.00	Number of interns & residents (see instructions)	23.71	4.00
5.00	Indirect medical education percentage (see instructions)	9.14	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)	199,511	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	1.88	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	14.83	8.00
9.00	Sum of lines 7 and 8	16.71	9.00
10.00	Allowable disproportionate share percentage (see instructions)	3.44	10.00
11.00	Disproportionate share adjustment (see instructions)	75,090	11.00
12.00	Total prospective capital payments (see instructions)	2,519,520	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