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: 14-0224	Period: From 01/01/2018 To 06/30/2018	Worksheet S Parts I-III Date/Time Prepared: 11/28/2018 12:49 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/28/2018 Time: 12:49 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PRESENCE SAINT JOSEPH HOSP-CHICAGO (14-0224) for the cost reporting period beginning 01/01/2018 and ending 06/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[X] 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) FLAVIO MARIN
Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER
Title

(Dated when report is electronically signed.)
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	-63,978	-33,365	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	25,002	4		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	7,669	0		0	7.00
200.00	Total	0	-31,307	-33,361	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: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2018 10:50 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2900 NORTH LAKE SHORE DRIVE	PO Box:			1.00
2.00	City: CHICAGO	State: IL	Zip Code: 60657	County: COOK	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	PRESENCE SAINT JOSEPH HOSP-CHICAGO	140224	16974	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	REHAB UNIT	14T224	16974	5	07/01/1985	N	P	O	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	SKILLED CARE	145568	16974		01/28/1987	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2018	06/30/2018	20.00
21.00	Type of Control (see instructions)	1		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	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	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.	3	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.	1,673	1,088	0	0	1,600	114	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	54	135	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/28/2018 10:50 am

		Urban/Rural St	Date of Geogra	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0224	Period: From 01/01/2018 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/28/2018 10:50 am

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

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

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	Y	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)	8.12	29.85	0.213853	64.00

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	

		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)	FAMILY MEDICINE	1350	0.57	16.24	0.033908	65.00
65.01		INTERNAL MEDICINE	1400	2.88	62.28	0.044199	65.01

		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)	9.23	33.94	0.213806	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)	FAMILY MEDICINE	1350	0.97	17.01	0.053949	67.00
67.01		INTERNAL MEDICINE	1400	0.50	74.45	0.006671	67.01

		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.	Y			75.00

		1.00	2.00	3.00	
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)	N		0	76.00

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0224	Period: From 01/01/2018 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/28/2018 10:50 am

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	2,916,348	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/28/2018 10:50 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: PRESENCE HEALTH NETWORK	Contractor's Name: NGS	Contractor's Number: 00131	141.00
142.00	Street: 200 S. WACKER DRIVE	PO Box:		142.00
143.00	City: CHICAGO	State: IL	Zip Code: 60606	143.00

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

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

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

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

		1.00	
	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)	0.00	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)	01/01/2018	06/30/2018	170.00

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet S-2 Part II Date/Time Prepared: 11/28/2018 10:50 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	09/12/2018	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	11/05/2018	Y	11/05/2018	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0224	Period: From 01/01/2018 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/28/2018 10:50 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	Y	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	Y	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICK	GILLILAND	41.00
42.00	Enter the employer/company name of the cost report preparer	PRSENCE HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	847-813-3718	PATRICK.GILLILAND@AMITAHEALTH.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0224	Period: From 01/01/2018 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/28/2018 10:50 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.	REGIONAL DIRECTOR OF REIMBURSEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet S-3 Part I Date/Time Prepared: 11/28/2018 10:50 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	258	46,698	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)		258	46,698	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	19	3,439	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)		277	50,137	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	10	1,810		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	26	4,706		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		313				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)		1	181			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: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet S-3 Part I Date/Time Prepared: 11/28/2018 10:50 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)	6,780	891	23,223			1.00
2.00	HMO and other (see instructions)	2,376	2,895				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	67	131				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)	6,780	891	23,223			7.00
8.00	INTENSIVE CARE UNIT	849	103	1,461			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		437	1,170			13.00
14.00	Total (see instructions)	7,629	1,431	25,854	117.73	1,005.58	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	358	58	738	0.00	9.16	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	2,746	0	3,442	0.00	27.69	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	119			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)				117.73	1,042.43	27.00
28.00	Observation Bed Days		270	2,063			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	149	344			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			19			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: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet S-3 Part I Date/Time Prepared: 11/28/2018 10:50 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	1,534	445	5,733	1.00
2.00	HMO and other (see instructions)			455	678		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	1,534	445	5,733	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	32	5	64	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet S-3 Part II Date/Time Prepared: 11/28/2018 10:50 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	35,504,042	170,546	35,674,588	1,072,637.29	33.26	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		575,661	0	575,661	4,553.00	126.44	4.00
4.01	Physicians - Part A - Teaching		306,186	0	306,186	4,486.69	68.24	4.01
5.00	Physician and Non Physician-Part B		143,331	0	143,331	1,005.00	142.62	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	4,038,571	4,038,571	144,529.00	27.94	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	962,522	0	962,522	28,799.31	33.42	9.00
10.00	Excluded area salaries (see instructions)		2,048,040	34,606	2,082,646	53,818.38	38.70	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,678,542	0	1,678,542	45,652.56	36.77	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		7,962,862	0	7,962,862	204,663.00	38.91	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		6,885,764	0	6,885,764			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		814,267	0	814,267			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		107,543	0	107,543			22.00
22.01	Physician Part A - Teaching		86,814	0	86,814			22.01
23.00	Physician Part B		24,932	0	24,932			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		1,446,008	0	1,446,008			25.00
25.50	Home office wage-related (core)		1,811,238	0	1,811,238			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	-170,546	170,546	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	3,263,234	0	3,263,234	93,283.77	34.98	27.00
28.00	Administrative & General under contract (see inst.)		2,479,461	0	2,479,461	13,373.00	185.41	28.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet S-3 Part II Date/Time Prepared: 11/28/2018 10:50 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	
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	60,340	0	60,340	4,333.40	13.92	31.00
32.00	Housekeeping	9.00	722,946	0	722,946	50,845.49	14.22	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	859,968	-425,834	434,134	28,147.33	15.42	34.00
35.00	Dietary under contract (see instructions)		412,220	0	412,220	8,960.00	46.01	35.00
36.00	Cafeteria	11.00	0	425,834	425,834	28,915.18	14.73	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	584,162	0	584,162	12,610.85	46.32	38.00
39.00	Central Services and Supply	14.00	87,966	0	87,966	4,482.20	19.63	39.00
40.00	Pharmacy	15.00	937,301	-34,606	902,695	25,421.48	35.51	40.00
41.00	Medical Records & Medical Records Library	16.00	42,929	0	42,929	1,520.00	28.24	41.00
42.00	Social Service	17.00	683,239	0	683,239	17,023.60	40.13	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet S-3 Part III Date/Time Prepared: 11/28/2018 10:50 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)		37,946,206	-3,868,025	34,078,181	944,949.60	36.06	1.00
2.00	Excluded area salaries (see instructions)		3,010,562	34,606	3,045,168	82,617.69	36.86	2.00
3.00	Subtotal salaries (line 1 minus line 2)		34,935,644	-3,902,631	31,033,013	862,331.91	35.99	3.00
4.00	Subtotal other wages & related costs (see inst.)		9,641,404	0	9,641,404	250,315.56	38.52	4.00
5.00	Subtotal wage-related costs (see inst.)		8,804,545	0	8,804,545	0.00	28.37	5.00
6.00	Total (sum of lines 3 thru 5)		53,381,593	-3,902,631	49,478,962	1,112,647.47	44.47	6.00
7.00	Total overhead cost (see instructions)		9,963,220	135,940	10,099,160	288,916.30	34.96	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet S-3 Part IV Date/Time Prepared: 11/28/2018 10:50 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,446,029	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)	1,046,693	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)	3,481,610	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	84,281	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	21,504	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)	116,904	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	420,907	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	2,618,386	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	36,789	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	92,224	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	9,365,327	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COST	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet S-3 Part V Date/Time Prepared: 11/28/2018 10:50 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	1,678,542	9,365,348	1.00
2.00	Hospital	1,678,542	6,808,599	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	77,185	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	276,577	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	2,202,987	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provider CCN: 14-0224	Period: From 01/01/2018 To 06/30/2018	Worksheet S-7 Date/Time Prepared: 11/28/2018 10:50 am

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N		2.00

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1.00	2.00	3.00	4.00	
3.00	RUX	0	0	0	3.00
4.00	RUL	7	0	7	4.00
5.00	RVX	0	0	0	5.00
6.00	RVL	14	0	14	6.00
7.00	RHX	0	0	0	7.00
8.00	RHL	0	0	0	8.00
9.00	RMX	0	0	0	9.00
10.00	RML	0	0	0	10.00
11.00	RLX	0	0	0	11.00
12.00	RUC	61	0	61	12.00
13.00	RUB	737	0	737	13.00
14.00	RUA	1,039	0	1,039	14.00
15.00	RVC	53	0	53	15.00
16.00	RVB	251	0	251	16.00
17.00	RVA	327	0	327	17.00
18.00	RHC	11	0	11	18.00
19.00	RHB	63	0	63	19.00
20.00	RHA	16	0	16	20.00
21.00	RMC	0	0	0	21.00
22.00	RMB	8	0	8	22.00
23.00	RMA	0	0	0	23.00
24.00	RLB	0	0	0	24.00
25.00	RLA	0	0	0	25.00
26.00	ES3	0	0	0	26.00
27.00	ES2	0	0	0	27.00
28.00	ES1	0	0	0	28.00
29.00	HE2	0	0	0	29.00
30.00	HE1	0	0	0	30.00
31.00	HD2	0	0	0	31.00
32.00	HD1	0	0	0	32.00
33.00	HC2	0	0	0	33.00
34.00	HC1	0	0	0	34.00
35.00	HB2	0	0	0	35.00
36.00	HB1	28	0	28	36.00
37.00	LE2	0	0	0	37.00
38.00	LE1	0	0	0	38.00
39.00	LD2	0	0	0	39.00
40.00	LD1	6	0	6	40.00
41.00	LC2	0	0	0	41.00
42.00	LC1	2	0	2	42.00
43.00	LB2	0	0	0	43.00
44.00	LB1	0	0	0	44.00
45.00	CE2	0	0	0	45.00
46.00	CE1	0	0	0	46.00
47.00	CD2	0	0	0	47.00
48.00	CD1	0	0	0	48.00
49.00	CC2	0	0	0	49.00
50.00	CC1	16	0	16	50.00
51.00	CB2	0	0	0	51.00
52.00	CB1	53	0	53	52.00
53.00	CA2	0	0	0	53.00
54.00	CA1	38	0	38	54.00
55.00	SE3	0	0	0	55.00
56.00	SE2	0	0	0	56.00
57.00	SE1	0	0	0	57.00
58.00	SSC	0	0	0	58.00
59.00	SSB	0	0	0	59.00
60.00	SSA	0	0	0	60.00
61.00	IB2	0	0	0	61.00
62.00	IB1	0	0	0	62.00
63.00	IA2	0	0	0	63.00
64.00	IA1	0	0	0	64.00
65.00	BB2	0	0	0	65.00
66.00	BB1	0	0	0	66.00
67.00	BA2	0	0	0	67.00
68.00	BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet S-7 Date/Time Prepared: 11/28/2018 10:50 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	7	0	7	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	3	0	3	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	5	0	5	78.00
199.00		AAA	1	0	1	199.00
200.00	TOTAL		2,746	0	2,746	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	16974	16974	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	4,010,147			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet S-10 | Date/Time Prepared: 11/28/2018 10:50 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)	0.214001	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	8,827,608	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	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	65,445,659	6.00
7.00	Medicaid cost (line 1 times line 6)	14,005,436	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)	5,177,828	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)	5,177,828	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)	3,742,520	1,047,411	4,789,931	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	800,903	1,047,411	1,848,314	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)	800,903	1,047,411	1,848,314	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)	4,075,891	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	111,285	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	171,207	27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,904,684	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	895,528	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,743,842	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	7,921,670	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/28/2018 10:50 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		2,905,094	2,905,094	382,307	3,287,401	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	3,476,958	3,476,958	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-170,546	-611,006	-781,552	0	-781,552	4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	63,046	63,046	5.01
5.02	00550	DATA PROCESSING	0	0	0	0	0	5.02
5.03	00560	PURCHASING,RECEIVING&STORES	0	0	0	0	0	5.03
5.04	00570	ADMITTING	0	0	0	0	0	5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	0	0	0	0	0	5.05
5.06	00591	ADMINISTRATION & GENERAL	3,263,234	37,462,540	40,725,774	-2,382,742	38,343,032	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	11,475	11,475	-11,473	2	6.00
7.00	00700	OPERATION OF PLANT	0	1,219,738	1,219,738	-15,048	1,204,690	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	60,340	272,002	332,342	0	332,342	8.00
9.00	00900	HOUSEKEEPING	722,946	812,195	1,535,141	-2,480	1,532,661	9.00
10.00	01000	DIETARY	859,968	1,378,499	2,238,467	-1,162,881	1,075,586	10.00
11.00	01100	CAFETERIA	0	0	0	1,148,016	1,148,016	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	584,162	230,359	814,521	-106,115	708,406	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	87,966	-124,523	-36,557	-29,962	-66,519	14.00
15.00	01500	PHARMACY	937,301	2,576,892	3,514,193	-2,151,001	1,363,192	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	42,929	109,690	152,619	-27,285	125,334	16.00
17.00	01700	SOCIAL SERVICE	683,239	293,840	977,079	-923	976,156	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	5,335,112	5,335,112	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	5,765,356	2,774,602	8,539,958	-5,764,014	2,775,944	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	127,676	18,611	146,287	42,912	189,199	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,427,387	4,059,532	12,486,919	-441,479	12,045,440	30.00
31.00	03100	INTENSIVE CARE UNIT	1,128,450	429,796	1,558,246	-118,353	1,439,893	31.00
41.00	04100	SUBPROVIDER - IRF	308,992	86,694	395,686	-2,889	392,797	41.00
43.00	04300	NURSERY	740,929	206,664	947,593	304,434	1,252,027	43.00
44.00	04400	SKILLED NURSING FACILITY	962,522	368,691	1,331,213	-27,234	1,303,979	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,796,112	8,974,483	11,770,595	-4,195,773	7,574,822	50.00
51.00	05100	RECOVERY ROOM	296,918	81,266	378,184	-19,727	358,457	51.00
53.00	05300	ANESTHESIOLOGY	55,256	609,325	664,581	-182,958	481,623	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,236,271	799,265	2,035,536	-280,086	1,755,450	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	592,929	561,412	1,154,341	-65,295	1,089,046	55.00
57.00	05700	CT SCAN	194,951	99,297	294,248	-21,541	272,707	57.00
58.00	05800	MRI	156,648	195,523	352,171	-150,259	201,912	58.00
59.00	05900	CARDIAC CATHETERIZATION	584,359	1,132,411	1,716,770	-452,467	1,264,303	59.00
60.00	06000	LABORATORY	0	3,722,848	3,722,848	-54,286	3,668,562	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	197,645	197,645	6,033	203,678	63.00
65.00	06500	RESPIRATORY THERAPY	534,614	392,025	926,639	-32,540	894,099	65.00
66.00	06600	PHYSICAL THERAPY	1,125,261	382,320	1,507,581	-11,736	1,495,845	66.00
69.00	06900	ELECTROCARDIOLOGY	175,644	68,153	243,797	-18,137	225,660	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	26,313	14,981	41,294	-5,726	35,568	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,325,395	2,325,395	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,175,993	2,175,993	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,150,175	3,150,175	73.00
74.00	07400	RENAL DIALYSIS	0	187,469	187,469	0	187,469	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	45,579	11,125	56,704	-1,448	55,256	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	237,983	103,957	341,940	-19,728	322,212	90.00
91.00	09100	EMERGENCY	1,152,893	844,141	1,997,034	-200,462	1,796,572	91.00
91.01	09101	PARTIAL HOSPITALIZATION	148,088	34,989	183,077	-42	183,035	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,892,670	72,894,020	106,786,690	454,291	107,240,981	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER	1,611,372	1,181,243	2,792,615	-454,291	2,338,324	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	35,504,042	74,075,263	109,579,305	0	109,579,305	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/28/2018 10:50 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	195,089	3,482,490	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,931,433	6,408,391	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-120,037	-901,589	4.00
5.01	00540	NONPATIENT TELEPHONES	0	63,046	5.01
5.02	00550	DATA PROCESSING	1,832,175	1,832,175	5.02
5.03	00560	PURCHASING,RECEIVING&STORES	-149,015	-149,015	5.03
5.04	00570	ADMITTING	0	0	5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	2,262,747	2,262,747	5.05
5.06	00591	ADMINISTRATION & GENERAL	222,300	38,565,332	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	2	6.00
7.00	00700	OPERATION OF PLANT	0	1,204,690	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	332,342	8.00
9.00	00900	HOUSEKEEPING	0	1,532,661	9.00
10.00	01000	DIETARY	-280	1,075,306	10.00
11.00	01100	CAFETERIA	-556,537	591,479	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	708,406	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	430,250	363,731	14.00
15.00	01500	PHARMACY	0	1,363,192	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	653,337	778,671	16.00
17.00	01700	SOCIAL SERVICE	0	976,156	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	5,335,112	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	-157,442	2,618,502	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	189,199	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-610,023	11,435,417	30.00
31.00	03100	INTENSIVE CARE UNIT	197,229	1,637,122	31.00
41.00	04100	SUBPROVIDER - IRF	0	392,797	41.00
43.00	04300	NURSERY	-744	1,251,283	43.00
44.00	04400	SKILLED NURSING FACILITY	-21,391	1,282,588	44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-360,239	7,214,583	50.00
51.00	05100	RECOVERY ROOM	0	358,457	51.00
53.00	05300	ANESTHESIOLOGY	-351,165	130,458	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-15,355	1,740,095	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,089,046	55.00
57.00	05700	CT SCAN	0	272,707	57.00
58.00	05800	MRI	0	201,912	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,264,303	59.00
60.00	06000	LABORATORY	-91,248	3,577,314	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	203,678	63.00
65.00	06500	RESPIRATORY THERAPY	0	894,099	65.00
66.00	06600	PHYSICAL THERAPY	-48,862	1,446,983	66.00
69.00	06900	ELECTROCARDIOLOGY	0	225,660	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	35,568	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,325,395	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,175,993	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,150,175	73.00
74.00	07400	RENAL DIALYSIS	0	187,469	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	55,256	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	-1,268	320,944	90.00
91.00	09100	EMERGENCY	-184,631	1,611,941	91.00
91.01	09101	PARTIAL HOSPITALIZATION	-13,000	170,035	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,043,323	113,284,304	118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	OTHER	-790,471	1,547,853	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	5,252,852	114,832,157	200.00

RECLASSIFICATIONS | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/28/2018 10:50 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,150,175	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
	TOTALS		0	3,150,175	
	B - IMPLANTS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,175,993	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
	TOTALS		0	2,175,993	
	C - CHARGABLE SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,325,395	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
	TOTALS		0	2,325,395	

RECLASSIFICATIONS | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/28/2018 10:50 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	D - NURSEY				
1.00	NURSERY	43.00	246,215	87,467	1.00
	TOTALS		246,215	87,467	
	E - CAFETERIA				
1.00	CAFETERIA	11.00	425,834	722,182	1.00
	TOTALS		425,834	722,182	
	F - PHYSICIAN DEPR CHAIRMAN				
1.00	ADULTS & PEDIATRICS	30.00	377,349	48,563	1.00
	TOTALS		377,349	48,563	
	G - SALARY EARNED TIME OFF ACCRUAL				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	170,546	0	1.00
	TOTALS		170,546	0	
	H - EQUIP DEPRECIATION				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	382,307	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,476,958	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
	TOTALS		0	3,859,265	
	I - PHONES				
1.00	NONPATIENT TELEPHONES	5.01	0	63,046	1.00
	TOTALS		0	63,046	
	J - PHARMACY RESIDENCY COSTS				
1.00	PARAMED ED PRGM-(SPECIFY)	23.00	34,606	8,306	1.00
	TOTALS		34,606	8,306	
	L - INTERNS AND RESIDENTS SALARY				
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	4,038,571	1,296,541	1.00
	TOTALS		4,038,571	1,296,541	
	M - BLOOD RECLASS				
1.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	6,033	1.00
	TOTALS		0	6,033	
500.00	Grand Total: Increases		5,293,121	13,742,966	500.00

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DRUGS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	9,014	0		1.00
2.00	PHARMACY	15.00	0	2,088,807	0		2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	0	22,065	0		3.00
4.00	SOCIAL SERVICE	17.00	0	923	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	154,978	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	22,752	0		6.00
7.00	SUBPROVIDER - IRF	41.00	0	250	0		7.00
8.00	NURSERY	43.00	0	5,074	0		8.00
9.00	SKILLED NURSING FACILITY	44.00	0	8,159	0		9.00
10.00	OPERATING ROOM	50.00	0	121,978	0		10.00
11.00	RECOVERY ROOM	51.00	0	3,558	0		11.00
12.00	ANESTHESIOLOGY	53.00	0	104,227	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,304	0		13.00
14.00	RADIOLOGY-THERAPEUTIC	55.00	0	26,430	0		14.00
15.00	CT SCAN	57.00	0	19,637	0		15.00
16.00	MRI	58.00	0	25,241	0		16.00
17.00	CARDIAC CATHETERIZATION	59.00	0	57,113	0		17.00
18.00	LABORATORY	60.00	0	324	0		18.00
19.00	RESPIRATORY THERAPY	65.00	0	2,986	0		19.00
20.00	ELECTROCARDIOLOGY	69.00	0	2,060	0		20.00
21.00	ELECTROENCEPHALOGRAPHY	70.00	0	5	0		21.00
22.00	CLINIC	90.00	0	4,734	0		22.00
23.00	EMERGENCY	91.00	0	47,275	0		23.00
24.00	OTHER	194.00	0	417,281	0		24.00
	TOTALS		0	3,150,175			
	B - IMPLANTS						
1.00	MEDICAL RECORDS & LIBRARY	16.00	0	928	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	14,789	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	5,583	0		3.00
4.00	SUBPROVIDER - IRF	41.00	0	23	0		4.00
5.00	SKILLED NURSING FACILITY	44.00	0	209	0		5.00
6.00	OPERATING ROOM	50.00	0	1,856,277	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	8,438	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	730	0		8.00
9.00	CT SCAN	57.00	0	1,875	0		9.00
10.00	CARDIAC CATHETERIZATION	59.00	0	264,097	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	344	0		11.00
12.00	ELECTROCARDIOLOGY	69.00	0	69	0		12.00
13.00	CLINIC	90.00	0	5,632	0		13.00
14.00	EMERGENCY	91.00	0	16,999	0		14.00
	TOTALS		0	2,175,993			
	C - CHARGABLE SUPPLIES						
1.00	ADMINISTRATION & GENERAL	5.06	0	125	0		1.00
2.00	HOUSEKEEPING	9.00	0	1,100	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,761	0		3.00
4.00	PHARMACY	15.00	0	2,237	0		4.00
5.00	MEDICAL RECORDS & LIBRARY	16.00	0	3,933	0		5.00
6.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	2,000	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	209,284	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	51,659	0		8.00
9.00	SUBPROVIDER - IRF	41.00	0	1,887	0		9.00
10.00	NURSERY	43.00	0	16,535	0		10.00
11.00	SKILLED NURSING FACILITY	44.00	0	14,641	0		11.00
12.00	OPERATING ROOM	50.00	0	1,882,058	0		12.00
13.00	RECOVERY ROOM	51.00	0	1,411	0		13.00
14.00	ANESTHESIOLOGY	53.00	0	50,379	0		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	14,037	0		15.00
16.00	RADIOLOGY-THERAPEUTIC	55.00	0	1,488	0		16.00
17.00	CT SCAN	57.00	0	29	0		17.00
18.00	MRI	58.00	0	22	0		18.00
19.00	CARDIAC CATHETERIZATION	59.00	0	12,165	0		19.00
20.00	LABORATORY	60.00	0	395	0		20.00
21.00	RESPIRATORY THERAPY	65.00	0	9,960	0		21.00
22.00	PHYSICAL THERAPY	66.00	0	2,598	0		22.00
23.00	ELECTROCARDIOLOGY	69.00	0	601	0		23.00
24.00	ELECTROENCEPHALOGRAPHY	70.00	0	4,787	0		24.00
25.00	CARDIAC REHABILITATION	76.97	0	7	0		25.00
26.00	CLINIC	90.00	0	9,222	0		26.00
27.00	EMERGENCY	91.00	0	26,796	0		27.00
28.00	OTHER	194.00	0	3,278	0		28.00
	TOTALS		0	2,325,395			

RECLASSIFICATIONS | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/28/2018 10:50 am

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	D - NURSEY					
1.00	ADULTS & PEDIATRICS	30.00	246,215	87,467	0	1.00
	TOTALS		246,215	87,467		
	E - CAFETERIA					
1.00	DIETARY	10.00	425,834	722,182	0	1.00
	TOTALS		425,834	722,182		
	F - PHYSICIAN DEPR CHAIRMAN					
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	377,349	48,563	0	1.00
	TOTALS		377,349	48,563		
	G - SALARY EARNED TIME OFF ACCRUAL					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	170,546	0	1.00
	TOTALS		0	170,546		
	H - EQUIP DEPRECIATION					
1.00	ADMINISTRATION & GENERAL	5.06	0	2,319,571	9	1.00
2.00	MAINTENANCE & REPAIRS	6.00	0	11,473	9	2.00
3.00	OPERATION OF PLANT	7.00	0	15,048	0	3.00
4.00	HOUSEKEEPING	9.00	0	1,380	0	4.00
5.00	DIETARY	10.00	0	14,865	0	5.00
6.00	NURSING ADMINISTRATION	13.00	0	106,115	0	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	18,187	0	7.00
8.00	PHARMACY	15.00	0	17,045	0	8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	359	0	9.00
10.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	990	0	10.00
11.00	ADULTS & PEDIATRICS	30.00	0	154,658	0	11.00
12.00	INTENSIVE CARE UNIT	31.00	0	38,359	0	12.00
13.00	SUBPROVIDER - IRF	41.00	0	729	0	13.00
14.00	NURSERY	43.00	0	7,639	0	14.00
15.00	SKILLED NURSING FACILITY	44.00	0	4,225	0	15.00
16.00	OPERATING ROOM	50.00	0	335,460	0	16.00
17.00	RECOVERY ROOM	51.00	0	14,758	0	17.00
18.00	ANESTHESIOLOGY	53.00	0	19,914	0	18.00
19.00	RADIOLOGY-DIAGNOSTIC	54.00	0	260,015	0	19.00
20.00	RADIOLOGY-THERAPEUTIC	55.00	0	37,377	0	20.00
21.00	MRI	58.00	0	124,996	0	21.00
22.00	CARDIAC CATHETERIZATION	59.00	0	119,092	0	22.00
23.00	LABORATORY	60.00	0	47,534	0	23.00
24.00	RESPIRATORY THERAPY	65.00	0	19,250	0	24.00
25.00	PHYSICAL THERAPY	66.00	0	9,138	0	25.00
26.00	ELECTROCARDIOLOGY	69.00	0	15,407	0	26.00
27.00	ELECTROENCEPHALOGRAPHY	70.00	0	934	0	27.00
28.00	CARDIAC REHABILITATION	76.97	0	1,441	0	28.00
29.00	CLINIC	90.00	0	140	0	29.00
30.00	EMERGENCY	91.00	0	109,392	0	30.00
31.00	PARTIAL HOSPITALIZATION	91.01	0	42	0	31.00
32.00	OTHER	194.00	0	33,732	0	32.00
	TOTALS		0	3,859,265		
	I - PHONES					
1.00	ADMINISTRATION & GENERAL	5.06	0	63,046	0	1.00
	TOTALS		0	63,046		
	J - PHARMACY RESIDENCY COSTS					
1.00	PHARMACY	15.00	34,606	8,306	0	1.00
	TOTALS		34,606	8,306		
	L - INTERNS AND RESIDENTS SALARY					
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	4,038,571	1,296,541	0	1.00
	TOTALS		4,038,571	1,296,541		
	M - BLOOD RECLASS					
1.00	LABORATORY	60.00	0	6,033	0	1.00
	TOTALS		0	6,033		
500.00	Grand Total: Decreases		5,122,575	13,913,512		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet A-7 Part I Date/Time Prepared: 11/28/2018 10:50 am

		Beginning Balances	Acquisitions Purchases	Acquisitions Donation	Acquisitions Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	7,327,666	18,742,334	0	18,742,334	0	1.00
2.00	Land Improvements	2,510,766	0	0	0	2,103,302	2.00
3.00	Buildings and Fixtures	97,286,916	0	0	0	31,790,832	3.00
4.00	Building Improvements	22,543,500	0	0	0	22,543,500	4.00
5.00	Fixed Equipment	32,231,265	0	0	0	21,504,373	5.00
6.00	Movable Equipment	74,247,532	0	0	0	67,835,983	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	236,147,645	18,742,334	0	18,742,334	145,777,990	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	236,147,645	18,742,334	0	18,742,334	145,777,990	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	26,070,000	0	1.00
2.00	Land Improvements	407,464	0	2.00
3.00	Buildings and Fixtures	65,496,084	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	10,726,892	0	5.00
6.00	Movable Equipment	6,411,549	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	109,111,989	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	109,111,989	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet A-7 Part II Date/Time Prepared: 11/28/2018 10:50 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	2,905,094	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,905,094	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	2,905,094	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	2,905,094	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet A-7 Part III Date/Time Prepared: 11/28/2018 10:50 am

	Cost Center Description	COMPUTATION OF RATIOS Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	161,900,113	0	161,900,113	0.685589	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	74,247,532	0	74,247,532	0.314411	0	2.00
3.00	Total (sum of lines 1-2)	236,147,645	0	236,147,645	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	3,663,295	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	6,408,391	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	10,071,686	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	-180,805	0	0	0	3,482,490	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	6,408,391	2.00
3.00	Total (sum of lines 1-2)	-180,805	0	0	0	9,890,881	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/28/2018 10:50 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	-1,930,622			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	7,376,469			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-556,537	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	375,894	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	2,913,125	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME	B	-744	NURSERY	43.00	0	33.00
34.00	MISC REVENUE	B	-3,355	RADIOLOGY-DIAGNOSTIC	54.00	0	34.00
38.00	MISC INCOME	A	-1,268	CLINIC	90.00	0	38.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/28/2018 10:50 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	
39.00	MOONLIGHTERS	A	-157,442	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	39.00
40.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	40.00
42.00	PHYS FEES	A	-790,471	OTHER	194.00	0	42.00
43.02	MISC INCOME	B	-280	DIETARY	10.00	0	43.02
43.03	MISC INCOME	B	-1,773,128	ADMINISTRATION & GENERAL	5.06	0	43.03
43.04	MISC INCOME		0		0.00	0	43.04
43.05	MISC INCOME		0		0.00	0	43.05
43.10	MISC INCOME		0		0.00	0	43.10
44.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.00
45.00	MISC INCOME		0		0.00	0	45.00
46.00	MISC INCOME	B	-1,392	SKILLED NURSING FACILITY	44.00	0	46.00
47.00	MISC INCOME		0		0.00	0	47.00
48.00	BENEFITS ON PART B DOCS	A	-197,397	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	48.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		5,252,852				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: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet A-8-1 | Date/Time Prepared: 11/28/2018 10:50 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	4.00	EMPLOYEE BENEFITS DEPARTMENT	EMPLOYEE BENEFITS	77,360	0	1.00
2.00	5.05	CASHIERING/ACCTS RECEIVABLE	PATIENT ACCOUNTS	2,262,747	0	2.00
3.00	5.02	DATA PROCESSING	IT	1,832,175	0	3.00
3.01	5.03	PURCHASING,RECEIVING&STORES	PURCHASING	-149,015	0	3.01
3.02	5.06	ADMINISTRATION & GENERAL	A & G	15,870,994	13,589,085	3.02
3.03	14.00	CENTRAL SERVICES & SUPPLY	CENTRAL SERVICES	430,250	0	3.03
3.04	31.00	INTENSIVE CARE UNIT	EICU	197,229	0	3.04
3.05	2.00	CAP REL COSTS-MVBLE EQUIP	CRC	18,308	0	3.05
3.06	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE INTEREST	-180,805	0	3.06
3.07	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	653,337	0	3.07
4.00	60.00	LABORATORY	ALVERNO LAB	3,577,518	3,624,544	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			24,590,098	17,213,629	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.

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

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

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

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	B		100.00	PRESENCE HEALTH	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					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: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet A-8-1 | Date/Time Prepared: 11/28/2018 10:50 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	77,360	0		1.00
2.00	2,262,747	0		2.00
3.00	1,832,175	0		3.00
3.01	-149,015	0		3.01
3.02	2,281,909	0		3.02
3.03	430,250	0		3.03
3.04	197,229	0		3.04
3.05	18,308	9		3.05
3.06	-180,805	11		3.06
3.07	653,337	0		3.07
4.00	-47,026	0		4.00
5.00	7,376,469			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	SOLE CORPORATE MEMBER		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet A-8-2 | Date/Time Prepared: 11/28/2018 10:50 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	912,344	521,995	390,349	179,000	3,513	1.00
2.00	44.00	SKILLED NURSING FACILITY	19,999	19,999	0	179,000	0	2.00
3.00	50.00	OPERATING ROOM	360,239	360,239	0	179,000	0	3.00
4.00	53.00	ANESTHESIOLOGY	351,165	351,165	0	179,000	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	12,000	12,000	0	179,000	0	5.00
6.00	60.00	LABORATORY	44,222	44,222	0	179,000	0	6.00
7.00	66.00	PHYSICAL THERAPY	48,862	48,862	0	179,000	0	7.00
8.00	91.00	EMERGENCY	184,631	184,631	0	179,000	0	8.00
9.00	91.01	PARTIAL HOSPITALIZATION	13,000	13,000	0	179,000	0	9.00
10.00	5.06	ADMINISTRATION & GENERAL	375,981	190,669	185,312	179,000	1,040	10.00
200.00			2,322,443	1,746,782	575,661		4,553	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	302,321	15,116	0	0	0	1.00
2.00	44.00	SKILLED NURSING FACILITY	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	91.01	PARTIAL HOSPITALIZATION	0	0	0	0	0	9.00
10.00	5.06	ADMINISTRATION & GENERAL	89,500	4,475	0	0	0	10.00
200.00			391,821	19,591	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	302,321	88,028	610,023		1.00
2.00	44.00	SKILLED NURSING FACILITY	0	0	0	19,999		2.00
3.00	50.00	OPERATING ROOM	0	0	0	360,239		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	351,165		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	12,000		5.00
6.00	60.00	LABORATORY	0	0	0	44,222		6.00
7.00	66.00	PHYSICAL THERAPY	0	0	0	48,862		7.00
8.00	91.00	EMERGENCY	0	0	0	184,631		8.00
9.00	91.01	PARTIAL HOSPITALIZATION	0	0	0	13,000		9.00
10.00	5.06	ADMINISTRATION & GENERAL	0	89,500	95,812	286,481		10.00
200.00			0	391,821	183,840	1,930,622		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/28/2018 10:50 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,482,490	3,482,490				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	6,408,391		6,408,391			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-901,589	0	0	-901,589		4.00
5.01	00540	NONPATIENT TELEPHONES	63,046	0	0	0	63,046	5.01
5.02	00550	DATA PROCESSING	1,832,175	0	0	0	0	5.02
5.03	00560	PURCHASING,RECEIVING&STORES	-149,015	0	0	0	1,020	5.03
5.04	00570	ADMITTING	0	0	0	0	1,813	5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	2,262,747	842	1,549	0	2,832	5.05
5.06	00591	ADMINISTRATION & GENERAL	38,565,332	1,182,471	2,175,955	0	7,704	5.06
6.00	00600	MAINTENANCE & REPAIRS	2	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,204,690	124,605	229,295	0	2,606	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	332,342	7,641	14,061	0	227	8.00
9.00	00900	HOUSEKEEPING	1,532,661	134,959	248,348	0	340	9.00
10.00	01000	DIETARY	1,075,306	128,739	236,901	0	453	10.00
11.00	01100	CAFETERIA	591,479	0	0	0	680	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	708,406	13,249	24,380	0	2,719	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	363,731	0	0	0	283	14.00
15.00	01500	PHARMACY	1,363,192	24,438	44,970	0	1,133	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	778,671	51,413	94,609	0	2,153	16.00
17.00	01700	SOCIAL SERVICE	976,156	0	0	0	850	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	5,335,112	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	2,618,502	20,405	37,549	0	3,002	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	189,199	451	830	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,435,417	785,242	1,444,983	0	9,629	30.00
31.00	03100	INTENSIVE CARE UNIT	1,637,122	96,243	177,103	0	2,209	31.00
41.00	04100	SUBPROVIDER - IRF	392,797	40,931	75,321	0	1,303	41.00
43.00	04300	NURSERY	1,251,283	23,785	43,768	0	453	43.00
44.00	04400	SKILLED NURSING FACILITY	1,282,588	102,160	187,992	0	680	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,214,583	267,750	492,707	0	4,645	50.00
51.00	05100	RECOVERY ROOM	358,457	13,929	25,631	0	0	51.00
53.00	05300	ANESTHESIOLOGY	130,458	5,911	10,877	0	113	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,740,095	141,940	261,195	0	4,588	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,089,046	39,147	72,038	0	0	55.00
57.00	05700	CT SCAN	272,707	10,455	19,239	0	0	57.00
58.00	05800	MRI	201,912	5,756	10,592	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,264,303	66,271	121,950	0	0	59.00
60.00	06000	LABORATORY	3,577,314	73,454	135,169	0	3,285	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	203,678	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	894,099	21,637	39,816	0	793	65.00
66.00	06600	PHYSICAL THERAPY	1,446,983	44,122	81,193	0	1,586	66.00
69.00	06900	ELECTROCARDIOLOGY	225,660	0	0	0	906	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	35,568	256	471	0	736	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,325,395	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,175,993	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,150,175	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	187,469	0	0	0	340	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	55,256	0	0	0	170	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	320,944	3,662	6,739	0	2,379	90.00
91.00	09100	EMERGENCY	1,611,941	0	0	0	1,416	91.00
91.01	09101	PARTIAL HOSPITALIZATION	170,035	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	113,284,304	3,431,864	6,315,231	0	63,046	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER	1,547,853	50,626	93,160	0	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	-901,589	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/28/2018 10:50 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
202.00		TOTAL (sum lines 118 through 201)	114,832,157	3,482,490	6,408,391	-901,589	63,046	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/28/2018 10:50 am

		Cost Center Description	DATA PROCESSING	PURCHASING, RECEIVING&STORES	ADMITTING	CASHIERING/ACCTS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	1,832,175					5.02
5.03	00560	PURCHASING, RECEIVING&STORES	0	-147,995				5.03
5.04	00570	ADMITTING	0	0	1,813			5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	0	0	0	2,267,970		5.05
5.06	00591	ADMINISTRATION & GENERAL	1,832,175	0	0	0	43,763,637	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	2	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	1,561,196	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	354,271	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	1,916,308	9.00
10.00	01000	DIETARY	0	0	0	0	1,441,399	10.00
11.00	01100	CAFETERIA	0	0	0	0	592,159	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	748,754	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	364,014	14.00
15.00	01500	PHARMACY	0	0	0	0	1,433,733	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	926,846	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	977,006	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	5,335,112	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	2,679,458	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	190,480	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	447	381,976	14,057,694	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	61	42,141	1,954,879	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	14	9,457	519,823	41.00
43.00	04300	NURSERY	0	0	68	46,886	1,366,243	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	28	19,493	1,592,941	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	162	328,944	8,308,791	50.00
51.00	05100	RECOVERY ROOM	0	0	26	38,059	436,102	51.00
53.00	05300	ANESTHESIOLOGY	0	0	34	66,960	214,353	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	47	138,875	2,286,740	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	3	52,213	1,252,447	55.00
57.00	05700	CT SCAN	0	0	40	79,140	381,581	57.00
58.00	05800	MRI	0	0	12	38,700	256,972	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	41	46,711	1,499,276	59.00
60.00	06000	LABORATORY	0	0	165	211,849	4,001,236	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	8	6,956	210,642	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	47	35,104	991,496	65.00
66.00	06600	PHYSICAL THERAPY	0	0	29	24,103	1,598,016	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	46	69,335	295,947	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	2	5,751	42,784	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	93	128,780	2,454,268	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	89	100,400	2,276,482	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	283	265,499	3,415,957	73.00
74.00	07400	RENAL DIALYSIS	0	0	7	5,724	193,540	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,984	57,410	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	1	8,216	341,941	90.00
91.00	09100	EMERGENCY	0	0	59	111,708	1,725,124	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	3,006	173,041	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,832,175	0	1,812	2,267,970	114,190,101	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER	0	0	1	0	1,691,640	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	-147,995	0	0	-1,049,584	201.00
202.00		TOTAL (sum lines 118 through 201)	1,832,175	-147,995	1,813	2,267,970	114,832,157	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/28/2018 10:50 am

		Cost Center Description	ADMINISTRATION & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.06	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING, RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL	43,763,637					5.06
6.00	00600	MAINTENANCE & REPAIRS	1	3				6.00
7.00	00700	OPERATION OF PLANT	947,385	0	2,508,581			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	214,983	0	8,815	578,069		8.00
9.00	00900	HOUSEKEEPING	1,162,879	0	155,688	0	3,234,875	9.00
10.00	01000	DIETARY	874,688	0	148,512	0	204,950	10.00
11.00	01100	CAFETERIA	359,342	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	454,369	0	15,284	0	21,092	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	220,896	0	0	0	0	14.00
15.00	01500	PHARMACY	870,036	0	28,191	0	38,904	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	562,441	0	59,310	0	81,849	16.00
17.00	01700	SOCIAL SERVICE	592,879	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	3,237,522	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	1,625,984	0	23,539	0	32,485	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	115,590	0	520	0	718	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,530,667	3	905,855	203,390	1,250,099	30.00
31.00	03100	INTENSIVE CARE UNIT	1,186,285	0	111,025	4,834	153,217	31.00
41.00	04100	SUBPROVIDER - IRF	315,446	0	47,218	18,147	65,162	41.00
43.00	04300	NURSERY	829,081	0	27,438	38,995	37,865	43.00
44.00	04400	SKILLED NURSING FACILITY	966,649	0	117,852	34,099	162,638	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,042,049	0	308,876	107,757	426,255	50.00
51.00	05100	RECOVERY ROOM	264,641	0	16,068	6,861	22,174	51.00
53.00	05300	ANESTHESIOLOGY	130,076	0	6,819	0	9,410	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,387,669	0	163,742	63,351	225,967	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	760,026	0	45,160	18,451	62,322	55.00
57.00	05700	CT SCAN	231,556	0	12,061	292	16,644	57.00
58.00	05800	MRI	155,939	0	6,640	0	9,163	58.00
59.00	05900	CARDIAC CATHETERIZATION	909,810	0	76,450	16,718	105,503	59.00
60.00	06000	LABORATORY	2,428,082	0	84,737	67	116,938	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	127,825	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	601,672	0	24,960	0	34,446	65.00
66.00	06600	PHYSICAL THERAPY	969,729	0	50,899	1,889	70,242	66.00
69.00	06900	ELECTROCARDIOLOGY	179,590	0	0	5,054	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	25,963	0	295	582	407	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,489,331	0	0	721	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,381,444	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,072,915	0	0	1,737	0	73.00
74.00	07400	RENAL DIALYSIS	117,446	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	34,838	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	207,501	0	4,225	4,968	5,830	90.00
91.00	09100	EMERGENCY	1,046,862	0	0	48,300	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	105,007	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	42,737,094	3	2,450,179	576,213	3,154,280	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER	1,026,543	0	58,402	1,856	80,595	194.00
194.01	07951	LAKESHORE GUEST UNIT	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)	43,763,637	3	2,508,581	578,069	3,234,875	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/28/2018 10:50 am

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING,RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	2,669,549					10.00
11.00	01100	CAFETERIA	0	951,501				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	13,766	0	1,253,265		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,914	0	43	589,867	14.00
15.00	01500	PHARMACY	0	27,088	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,657	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	18,577	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	158,389	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	27,213	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	4,233	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,211,150	274,935	0	661,725	0	30.00
31.00	03100	INTENSIVE CARE UNIT	68,185	29,369	0	106,598	0	31.00
41.00	04100	SUBPROVIDER - IRF	68,894	10,395	0	25,209	0	41.00
43.00	04300	NURSERY	0	26,691	0	61,638	0	43.00
44.00	04400	SKILLED NURSING FACILITY	321,320	31,560	0	52,797	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	87,881	0	165,609	0	50.00
51.00	05100	RECOVERY ROOM	0	7,467	0	24,113	0	51.00
53.00	05300	ANESTHESIOLOGY	0	2,917	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	35,146	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	18,918	0	9,684	0	55.00
57.00	05700	CT SCAN	0	5,515	0	0	0	57.00
58.00	05800	MRI	0	4,358	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	15,184	0	29,649	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	16,841	0	39	0	65.00
66.00	06600	PHYSICAL THERAPY	0	28,450	0	657	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	6,276	0	778	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,078	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	304,724	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	285,143	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,226	0	3,879	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	7,694	0	1,213	0	90.00
91.00	09100	EMERGENCY	0	35,373	0	94,857	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	4,256	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,669,549	907,367	0	1,238,488	589,867	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER	0	44,134	0	14,777	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	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)	2,669,549	951,501	0	1,253,265	589,867	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/28/2018 10:50 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING, RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	2,397,952					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,632,103				16.00
17.00	01700	SOCIAL SERVICE	0	0	1,588,462			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	274,931	1,233,707	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	30,325	76,097	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	6,805	38,439	0	0	41.00
43.00	04300	NURSERY	0	33,740	60,940	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	14,027	179,279	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	236,710	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	27,387	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	48,185	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	99,935	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	37,573	0	0	0	55.00
57.00	05700	CT SCAN	0	56,950	0	0	0	57.00
58.00	05800	MRI	0	27,849	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	33,614	0	0	0	59.00
60.00	06000	LABORATORY	0	152,448	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	5,006	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	25,261	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	17,344	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	49,894	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	4,139	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	92,671	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72,248	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,397,952	191,054	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	4,119	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,428	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	5,912	0	0	0	90.00
91.00	09100	EMERGENCY	0	80,385	0	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	2,163	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,397,952	1,632,103	1,588,462	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER	0	0	0	0	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,397,952	1,632,103	1,588,462	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/28/2018 10:50 am

		Cost Center Description	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			21.00	22.00	23.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING, RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	8,731,023					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		4,388,679				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			311,541			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,574,220	3,304,554	0	39,482,930	-9,878,774	30.00
31.00	03100	INTENSIVE CARE UNIT	563,855	283,424	0	4,568,093	-847,279	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	1,115,538	0	41.00
43.00	04300	NURSERY	0	0	0	2,482,631	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	3,473,162	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	937,320	471,147	0	16,092,395	-1,408,467	50.00
51.00	05100	RECOVERY ROOM	0	0	0	804,813	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	411,760	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	175,290	88,110	0	4,525,950	-263,400	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	2,204,581	0	55.00
57.00	05700	CT SCAN	0	0	0	704,599	0	57.00
58.00	05800	MRI	0	0	0	460,921	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	2,686,204	0	59.00
60.00	06000	LABORATORY	3,539	1,779	0	6,788,826	-5,318	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	343,473	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,694,715	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,737,226	0	66.00
69.00	06900	ELECTROCARDIOLOGY	69,361	34,865	0	641,765	-104,226	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	75,248	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,341,715	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,015,317	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	311,541	8,391,156	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	315,105	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	98,781	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,134	3,083	0	588,501	-9,217	90.00
91.00	09100	EMERGENCY	401,304	201,717	0	3,633,922	-603,021	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	284,467	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,731,023	4,388,679	311,541	112,963,794	-13,119,702	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER	0	0	0	2,917,947	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	-1,049,584	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/28/2018 10:50 am

	Cost Center Description	INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
		21.00	22.00	23.00	24.00	25.00	
202.00	TOTAL (sum lines 118 through 201)	8,731,023	4,388,679	311,541	114,832,157	-13,119,702	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/28/2018 10:50 am

		Cost Center Description	Total	
			26.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00540	NONPATIENT TELEPHONES		5.01
5.02	00550	DATA PROCESSING		5.02
5.03	00560	PURCHASING,RECEIVING&STORES		5.03
5.04	00570	ADMITTING		5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE		5.05
5.06	00591	ADMINISTRATION & GENERAL		5.06
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000	NURSING SCHOOL		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	29,604,156	30.00
31.00	03100	INTENSIVE CARE UNIT	3,720,814	31.00
41.00	04100	SUBPROVIDER - IRF	1,115,538	41.00
43.00	04300	NURSERY	2,482,631	43.00
44.00	04400	SKILLED NURSING FACILITY	3,473,162	44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	14,683,928	50.00
51.00	05100	RECOVERY ROOM	804,813	51.00
53.00	05300	ANESTHESIOLOGY	411,760	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,262,550	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,204,581	55.00
57.00	05700	CT SCAN	704,599	57.00
58.00	05800	MRI	460,921	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,686,204	59.00
60.00	06000	LABORATORY	6,783,508	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	343,473	63.00
65.00	06500	RESPIRATORY THERAPY	1,694,715	65.00
66.00	06600	PHYSICAL THERAPY	2,737,226	66.00
69.00	06900	ELECTROCARDIOLOGY	537,539	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	75,248	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,341,715	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,015,317	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,391,156	73.00
74.00	07400	RENAL DIALYSIS	315,105	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	76.00
76.97	07697	CARDIAC REHABILITATION	98,781	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	76.98
76.99	07699	LITHOTRIPSY	0	76.99
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	579,284	90.00
91.00	09100	EMERGENCY	3,030,901	91.00
91.01	09101	PARTIAL HOSPITALIZATION	284,467	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
		SPECIAL PURPOSE COST CENTERS		
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	99,844,092	118.00
		NONREIMBURSABLE COST CENTERS		
194.00	07950	OTHER	2,917,947	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	194.01
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	-1,049,584	201.00
202.00		TOTAL (sum lines 118 through 201)	101,712,455	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/28/2018 10:50 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	0	0	5.01
5.02	00550	DATA PROCESSING	0	0	0	0	0	5.02
5.03	00560	PURCHASING,RECEIVING&STORES	0	0	0	0	0	5.03
5.04	00570	ADMITTING	0	0	0	0	0	5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	0	842	1,549	2,391	0	5.05
5.06	00591	ADMINISTRATION & GENERAL	5,203,897	1,182,471	2,175,955	8,562,323	0	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	109	124,605	229,295	354,009	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	204	7,641	14,061	21,906	0	8.00
9.00	00900	HOUSEKEEPING	204	134,959	248,348	383,511	0	9.00
10.00	01000	DIETARY	4,929	128,739	236,901	370,569	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	3,229	13,249	24,380	40,858	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	35,448	0	0	35,448	0	14.00
15.00	01500	PHARMACY	71,335	24,438	44,970	140,743	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,455	51,413	94,609	148,477	0	16.00
17.00	01700	SOCIAL SERVICE	346	0	0	346	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
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	9,706	20,405	37,549	67,660	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	451	830	1,281	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,846	785,242	1,444,983	2,257,071	0	30.00
31.00	03100	INTENSIVE CARE UNIT	10,210	96,243	177,103	283,556	0	31.00
41.00	04100	SUBPROVIDER - IRF	477	40,931	75,321	116,729	0	41.00
43.00	04300	NURSERY	412	23,785	43,768	67,965	0	43.00
44.00	04400	SKILLED NURSING FACILITY	9,026	102,160	187,992	299,178	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	59,061	267,750	492,707	819,518	0	50.00
51.00	05100	RECOVERY ROOM	237	13,929	25,631	39,797	0	51.00
53.00	05300	ANESTHESIOLOGY	2,404	5,911	10,877	19,192	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,617	141,940	261,195	405,752	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	7,227	39,147	72,038	118,412	0	55.00
57.00	05700	CT SCAN	37	10,455	19,239	29,731	0	57.00
58.00	05800	MRI	0	5,756	10,592	16,348	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,082	66,271	121,950	191,303	0	59.00
60.00	06000	LABORATORY	6,897	73,454	135,169	215,520	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	2,112	21,637	39,816	63,565	0	65.00
66.00	06600	PHYSICAL THERAPY	39,425	44,122	81,193	164,740	0	66.00
69.00	06900	ELECTROCARDIOLOGY	2,919	0	0	2,919	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,019	256	471	1,746	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	27	0	0	27	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,082	3,662	6,739	11,483	0	90.00
91.00	09100	EMERGENCY	3,989	0	0	3,989	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	908	0	0	908	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,511,876	3,431,864	6,315,231	15,258,971	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER	279,505	50,626	93,160	423,291	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	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)	5,791,381	3,482,490	6,408,391	15,682,262	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/28/2018 10:50 am

		Cost Center Description	NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING, RECEIVING&STORES	ADMITTING	CASHIERING/ACCTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	0					5.01
5.02	00550	DATA PROCESSING	0	0				5.02
5.03	00560	PURCHASING, RECEIVING&STORES	0	0	0			5.03
5.04	00570	ADMITTING	0	0	0	0		5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	0	0	0	0	2,391	5.05
5.06	00591	ADMINISTRATION & GENERAL	0	0	0	0	0	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	0	9.00
10.00	01000	DIETARY	0	0	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
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
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	453	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	43	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	10	41.00
43.00	04300	NURSERY	0	0	0	0	48	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	20	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	338	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	39	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	69	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	143	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	54	55.00
57.00	05700	CT SCAN	0	0	0	0	81	57.00
58.00	05800	MRI	0	0	0	0	40	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	48	59.00
60.00	06000	LABORATORY	0	0	0	0	218	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	7	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	36	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	25	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	71	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	6	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	132	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	103	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	273	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	6	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	2	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	8	90.00
91.00	09100	EMERGENCY	0	0	0	0	115	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	0	3	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	0	2,391	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER	0	0	0	0	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	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)	0	0	0	0	2,391	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/28/2018 10:50 am

		Cost Center Description	ADMINISTRATION & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.06	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING, RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL	8,562,323					5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	185,355	0	539,364			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	42,061	0	1,895	65,862		8.00
9.00	00900	HOUSEKEEPING	227,516	0	33,474	0	644,501	9.00
10.00	01000	DIETARY	171,132	0	31,931	0	40,833	10.00
11.00	01100	CAFETERIA	70,305	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	88,897	0	3,286	0	4,202	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	43,218	0	0	0	0	14.00
15.00	01500	PHARMACY	170,221	0	6,061	0	7,751	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	110,041	0	12,752	0	16,307	16.00
17.00	01700	SOCIAL SERVICE	115,996	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	633,417	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	318,121	0	5,061	0	6,472	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	22,615	0	112	0	143	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,669,039	0	194,767	23,173	249,063	30.00
31.00	03100	INTENSIVE CARE UNIT	232,095	0	23,871	551	30,526	31.00
41.00	04100	SUBPROVIDER - IRF	61,717	0	10,152	2,068	12,983	41.00
43.00	04300	NURSERY	162,209	0	5,899	4,443	7,544	43.00
44.00	04400	SKILLED NURSING FACILITY	189,124	0	25,339	3,885	32,403	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	986,470	0	66,411	12,277	84,925	50.00
51.00	05100	RECOVERY ROOM	51,777	0	3,455	782	4,418	51.00
53.00	05300	ANESTHESIOLOGY	25,449	0	1,466	0	1,875	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	271,495	0	35,206	7,218	45,021	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	148,698	0	9,710	2,102	12,417	55.00
57.00	05700	CT SCAN	45,304	0	2,593	33	3,316	57.00
58.00	05800	MRI	30,509	0	1,428	0	1,826	58.00
59.00	05900	CARDIAC CATHETERIZATION	178,003	0	16,437	1,905	21,020	59.00
60.00	06000	LABORATORY	475,051	0	18,219	8	23,298	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	25,009	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	117,716	0	5,367	0	6,863	65.00
66.00	06600	PHYSICAL THERAPY	189,726	0	10,944	215	13,995	66.00
69.00	06900	ELECTROCARDIOLOGY	35,137	0	0	576	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,080	0	63	66	81	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	291,385	0	0	82	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	270,278	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	405,563	0	0	198	0	73.00
74.00	07400	RENAL DIALYSIS	22,978	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	6,816	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	40,597	0	908	566	1,162	90.00
91.00	09100	EMERGENCY	204,817	0	0	5,503	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	20,544	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,361,481	0	526,807	65,651	628,444	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER	200,842	0	12,557	211	16,057	194.00
194.01	07951	LAKESHORE GUEST UNIT	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)	8,562,323	0	539,364	65,862	644,501	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/28/2018 10:50 am

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING,RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	614,465					10.00
11.00	01100	CAFETERIA	0	70,305				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	1,017	0	138,260		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	363	0	5	79,034	14.00
15.00	01500	PHARMACY	0	2,002	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	122	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,373	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	11,703	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	2,011	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	313	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	508,953	20,313	0	73,001	0	30.00
31.00	03100	INTENSIVE CARE UNIT	15,694	2,170	0	11,760	0	31.00
41.00	04100	SUBPROVIDER - IRF	15,858	768	0	2,781	0	41.00
43.00	04300	NURSERY	0	1,972	0	6,800	0	43.00
44.00	04400	SKILLED NURSING FACILITY	73,960	2,332	0	5,825	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	6,493	0	18,270	0	50.00
51.00	05100	RECOVERY ROOM	0	552	0	2,660	0	51.00
53.00	05300	ANESTHESIOLOGY	0	215	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,597	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,398	0	1,068	0	55.00
57.00	05700	CT SCAN	0	408	0	0	0	57.00
58.00	05800	MRI	0	322	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,122	0	3,271	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	1,244	0	4	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,102	0	72	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	464	0	86	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	80	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	40,828	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	38,206	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	91	0	428	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	569	0	134	0	90.00
91.00	09100	EMERGENCY	0	2,614	0	10,465	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	314	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	614,465	67,044	0	136,630	79,034	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER	0	3,261	0	1,630	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	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)	614,465	70,305	0	138,260	79,034	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/28/2018 10:50 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING,RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	326,778					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	287,699				16.00
17.00	01700	SOCIAL SERVICE	0	0	117,715			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	48,312	91,425			30.00
31.00	03100	INTENSIVE CARE UNIT	0	5,349	5,639			31.00
41.00	04100	SUBPROVIDER - IRF	0	1,200	2,849			41.00
43.00	04300	NURSERY	0	5,951	4,516			43.00
44.00	04400	SKILLED NURSING FACILITY	0	2,474	13,286			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	41,752	0			50.00
51.00	05100	RECOVERY ROOM	0	4,831	0			51.00
53.00	05300	ANESTHESIOLOGY	0	8,499	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	17,627	0			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	6,627	0			55.00
57.00	05700	CT SCAN	0	10,045	0			57.00
58.00	05800	MRI	0	4,912	0			58.00
59.00	05900	CARDIAC CATHETERIZATION	0	5,929	0			59.00
60.00	06000	LABORATORY	0	26,890	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	883	0			63.00
65.00	06500	RESPIRATORY THERAPY	0	4,456	0			65.00
66.00	06600	PHYSICAL THERAPY	0	3,059	0			66.00
69.00	06900	ELECTROCARDIOLOGY	0	8,801	0			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	730	0			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	16,346	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	12,744	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	326,778	33,699	0			73.00
74.00	07400	RENAL DIALYSIS	0	727	0			74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0			76.00
76.97	07697	CARDIAC REHABILITATION	0	252	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,043	0			90.00
91.00	09100	EMERGENCY	0	14,179	0			91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	382	0			91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	326,778	287,699	117,715	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER	0	0	0			194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0			194.01
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	326,778	287,699	117,715	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/28/2018 10:50 am

		Cost Center Description	INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING,RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	645,120					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		399,325				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			24,464			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				5,135,570	0	30.00
31.00	03100	INTENSIVE CARE UNIT				611,254	0	31.00
41.00	04100	SUBPROVIDER - IRF				227,115	0	41.00
43.00	04300	NURSERY				267,347	0	43.00
44.00	04400	SKILLED NURSING FACILITY				647,826	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM				2,036,454	0	50.00
51.00	05100	RECOVERY ROOM				108,311	0	51.00
53.00	05300	ANESTHESIOLOGY				56,765	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				785,059	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC				300,486	0	55.00
57.00	05700	CT SCAN				91,511	0	57.00
58.00	05800	MRI				55,385	0	58.00
59.00	05900	CARDIAC CATHETERIZATION				419,038	0	59.00
60.00	06000	LABORATORY				759,204	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.				25,899	0	63.00
65.00	06500	RESPIRATORY THERAPY				199,251	0	65.00
66.00	06600	PHYSICAL THERAPY				384,878	0	66.00
69.00	06900	ELECTROCARDIOLOGY				48,054	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY				7,852	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				348,773	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				321,331	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				766,511	0	73.00
74.00	07400	RENAL DIALYSIS				23,711	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER				0	0	76.00
76.97	07697	CARDIAC REHABILITATION				7,616	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				0	0	76.98
76.99	07699	LITHOTRIPSY				0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC				56,470	0	90.00
91.00	09100	EMERGENCY				241,682	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION				22,151	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	13,955,504	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER				657,849	0	194.00
194.01	07951	LAKESHORE GUEST UNIT				0	0	194.01
200.00		Cross Foot Adjustments	645,120	399,325	24,464	1,068,909	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/28/2018 10:50 am

	Cost Center Description	INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
		21.00	22.00	23.00	24.00	25.00	
202.00	TOTAL (sum lines 118 through 201)	645,120	399,325	24,464	15,682,262	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/28/2018 10:50 am

		Cost Center Description	Total	
			26.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00540	NONPATIENT TELEPHONES		5.01
5.02	00550	DATA PROCESSING		5.02
5.03	00560	PURCHASING,RECEIVING&STORES		5.03
5.04	00570	ADMITTING		5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE		5.05
5.06	00591	ADMINISTRATION & GENERAL		5.06
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000	NURSING SCHOOL		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	5,135,570	30.00
31.00	03100	INTENSIVE CARE UNIT	611,254	31.00
41.00	04100	SUBPROVIDER - IRF	227,115	41.00
43.00	04300	NURSERY	267,347	43.00
44.00	04400	SKILLED NURSING FACILITY	647,826	44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	2,036,454	50.00
51.00	05100	RECOVERY ROOM	108,311	51.00
53.00	05300	ANESTHESIOLOGY	56,765	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	785,059	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	300,486	55.00
57.00	05700	CT SCAN	91,511	57.00
58.00	05800	MRI	55,385	58.00
59.00	05900	CARDIAC CATHETERIZATION	419,038	59.00
60.00	06000	LABORATORY	759,204	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	25,899	63.00
65.00	06500	RESPIRATORY THERAPY	199,251	65.00
66.00	06600	PHYSICAL THERAPY	384,878	66.00
69.00	06900	ELECTROCARDIOLOGY	48,054	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,852	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	348,773	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	321,331	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	766,511	73.00
74.00	07400	RENAL DIALYSIS	23,711	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	76.00
76.97	07697	CARDIAC REHABILITATION	7,616	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	76.98
76.99	07699	LITHOTRIPSY	0	76.99
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	56,470	90.00
91.00	09100	EMERGENCY	241,682	91.00
91.01	09101	PARTIAL HOSPITALIZATION	22,151	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
		SPECIAL PURPOSE COST CENTERS		
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,955,504	118.00
		NONREIMBURSABLE COST CENTERS		
194.00	07950	OTHER	657,849	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	194.01
200.00		Cross Foot Adjustments	1,068,909	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	15,682,262	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/28/2018 10:50 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF PHONES)	DATA PROCESSING (TIME SPENT)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	517,294					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		517,294				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	35,674,588			4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	1,113		5.01
5.02	00550	DATA PROCESSING	0	0	0	0	100	5.02
5.03	00560	PURCHASING,RECEIVING&STORES	0	0	0	18	0	5.03
5.04	00570	ADMITTING	0	0	0	32	0	5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	125	125	0	50	0	5.05
5.06	00591	ADMINISTRATION & GENERAL	175,646	175,646	3,263,234	136	100	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	18,509	18,509	0	46	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,135	1,135	60,340	4	0	8.00
9.00	00900	HOUSEKEEPING	20,047	20,047	722,946	6	0	9.00
10.00	01000	DIETARY	19,123	19,123	434,134	8	0	10.00
11.00	01100	CAFETERIA	0	0	425,834	12	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,968	1,968	584,162	48	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	87,966	5	0	14.00
15.00	01500	PHARMACY	3,630	3,630	902,695	20	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,637	7,637	42,929	38	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	683,239	15	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	4,038,571	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	3,031	3,031	1,349,436	53	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	67	67	162,282	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	116,641	116,641	8,558,521	170	0	30.00
31.00	03100	INTENSIVE CARE UNIT	14,296	14,296	1,128,450	39	0	31.00
41.00	04100	SUBPROVIDER - IRF	6,080	6,080	308,992	23	0	41.00
43.00	04300	NURSERY	3,533	3,533	987,144	8	0	43.00
44.00	04400	SKILLED NURSING FACILITY	15,175	15,175	962,522	12	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	39,772	39,772	2,796,112	82	0	50.00
51.00	05100	RECOVERY ROOM	2,069	2,069	296,918	0	0	51.00
53.00	05300	ANESTHESIOLOGY	878	878	55,256	2	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,084	21,084	1,236,271	81	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,815	5,815	592,929	0	0	55.00
57.00	05700	CT SCAN	1,553	1,553	194,951	0	0	57.00
58.00	05800	MRI	855	855	156,648	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,844	9,844	584,359	0	0	59.00
60.00	06000	LABORATORY	10,911	10,911	0	58	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	3,214	3,214	534,614	14	0	65.00
66.00	06600	PHYSICAL THERAPY	6,554	6,554	1,125,261	28	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	175,644	16	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	38	38	26,313	13	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	6	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	45,579	3	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	544	544	237,983	42	0	90.00
91.00	09100	EMERGENCY	0	0	1,152,893	25	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	148,088	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	509,774	509,774	34,063,216	1,113	100	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER	7,520	7,520	1,611,372	0	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/28/2018 10:50 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF PHONES)	DATA PROCESSING (TIME SPENT)	
			1.00	2.00	4.00	5.01	5.02	
202.00		Cost to be allocated (per Wkst. B, Part I)	3,482,490	6,408,391	-901,589	63,046	1,832,175	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.732129	12.388296	0.000000	56.645103	18,321.750000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/28/2018 10:50 am

		Cost Center Description	PURCHASING,RECEIVING&STORES (SUPPLY EXPENSE)	ADMITTING (INPATIENT REVENUE)	CASHIERING/ACCTS RECEIVABLE (GROSS REVENUE)	Reconciliation	ADMINISTRATION & GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING,RECEIVING&STORES	3,121,993					5.03
5.04	00570	ADMITTING	0	267,290,611				5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	0	0	466,558,041			5.05
5.06	00591	ADMINISTRATION & GENERAL	46,851	0	0	-43,763,637	72,118,104	5.06
6.00	00600	MAINTENANCE & REPAIRS	2	0	0	0	2	6.00
7.00	00700	OPERATION OF PLANT	30	0	0	0	1,561,196	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	354,271	8.00
9.00	00900	HOUSEKEEPING	1,473	0	0	0	1,916,308	9.00
10.00	01000	DIETARY	1,811	0	0	0	1,441,399	10.00
11.00	01100	CAFETERIA	0	0	0	0	592,159	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	4,474	0	0	0	748,754	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,489	0	0	0	364,014	14.00
15.00	01500	PHARMACY	57,509	0	0	0	1,433,733	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	18,468	0	0	0	926,846	16.00
17.00	01700	SOCIAL SERVICE	371	0	0	0	977,006	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	5,335,112	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	67,635	0	0	0	2,679,458	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	190,480	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	198,494	72,182,745	78,573,218	0	14,057,694	30.00
31.00	03100	INTENSIVE CARE UNIT	32,937	8,669,152	8,669,152	0	1,954,879	31.00
41.00	04100	SUBPROVIDER - IRF	3,149	1,945,404	1,945,404	0	519,823	41.00
43.00	04300	NURSERY	6,888	9,645,377	9,645,377	0	1,366,243	43.00
44.00	04400	SKILLED NURSING FACILITY	22,439	4,010,147	4,010,147	0	1,592,941	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	207,048	23,175,130	67,670,037	0	8,308,791	50.00
51.00	05100	RECOVERY ROOM	2,385	3,666,907	7,829,405	0	436,102	51.00
53.00	05300	ANESTHESIOLOGY	2,350	4,913,201	13,775,001	0	214,353	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,864	6,691,984	28,569,262	0	2,286,740	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	20,065	393,730	10,741,196	0	1,252,447	55.00
57.00	05700	CT SCAN	2,003	5,698,287	16,280,666	0	381,581	57.00
58.00	05800	MRI	1,178	1,683,537	7,961,407	0	256,972	58.00
59.00	05900	CARDIAC CATHETERIZATION	26,148	5,914,150	9,609,430	0	1,499,276	59.00
60.00	06000	LABORATORY	1,781	23,638,215	43,581,369	0	4,001,236	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	86	1,179,587	1,430,962	0	210,642	63.00
65.00	06500	RESPIRATORY THERAPY	1,142	6,690,016	7,221,573	0	991,496	65.00
66.00	06600	PHYSICAL THERAPY	2,057	4,179,043	4,958,387	0	1,598,016	66.00
69.00	06900	ELECTROCARDIOLOGY	1,196	6,519,367	14,263,513	0	295,947	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	107	256,915	1,183,168	0	42,784	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,325,393	13,335,640	26,492,591	0	2,454,268	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	12,737,390	20,654,088	0	2,276,482	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	40,443,589	54,618,150	0	3,415,957	73.00
74.00	07400	RENAL DIALYSIS	0	1,014,436	1,177,588	0	193,540	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	39	0	408,100	0	57,410	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,127	85,570	1,690,117	0	341,941	90.00
91.00	09100	EMERGENCY	30,033	8,460,939	22,980,412	0	1,725,124	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	3,066	618,321	0	173,041	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,108,022	267,133,524	466,558,041	-43,763,637	70,426,464	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER	13,971	157,087	0	0	1,691,640	194.00
194.01	07951	LAKESHORE GUEST UNIT	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)	-147,995	1,813	2,267,970		43,763,637	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000007	0.004861		0.606833	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/28/2018 10:50 am

	Cost Center Description	PURCHASING,RECEIVING&STORES (SUPPLY EXPENSE)	ADMITTING (INPATIENT REVENUE)	CASHIERING/ACCTS RECEIVABLE (GROSS REVENUE)	Reconciliation	ADMINISTRATION & GENERAL (ACCUM. COST)	
		5.03	5.04	5.05	5A.06	5.06	
204.00	Cost to be allocated (per Wkst. B, Part II)	0	0	2,391		8,562,323	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.000005		0.118726	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: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/28/2018 10:50 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY POUNDS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED))	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING,RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS	341,523					6.00
7.00	00700	OPERATION OF PLANT	18,509	323,014				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,135	1,135	514,804			8.00
9.00	00900	HOUSEKEEPING	20,047	20,047	0	301,832		9.00
10.00	01000	DIETARY	19,123	19,123	0	19,123	71,491	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,968	1,968	0	1,968	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	3,630	3,630	0	3,630	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,637	7,637	0	7,637	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
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	3,031	3,031	0	3,031	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	67	67	0	67	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	116,641	116,641	181,131	116,641	59,215	30.00
31.00	03100	INTENSIVE CARE UNIT	14,296	14,296	4,305	14,296	1,826	31.00
41.00	04100	SUBPROVIDER - IRF	6,080	6,080	16,161	6,080	1,845	41.00
43.00	04300	NURSERY	3,533	3,533	34,727	3,533	0	43.00
44.00	04400	SKILLED NURSING FACILITY	15,175	15,175	30,367	15,175	8,605	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	39,772	39,772	95,964	39,772	0	50.00
51.00	05100	RECOVERY ROOM	2,069	2,069	6,110	2,069	0	51.00
53.00	05300	ANESTHESIOLOGY	878	878	0	878	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,084	21,084	56,418	21,084	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,815	5,815	16,432	5,815	0	55.00
57.00	05700	CT SCAN	1,553	1,553	260	1,553	0	57.00
58.00	05800	MRI	855	855	0	855	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,844	9,844	14,888	9,844	0	59.00
60.00	06000	LABORATORY	10,911	10,911	60	10,911	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	3,214	3,214	0	3,214	0	65.00
66.00	06600	PHYSICAL THERAPY	6,554	6,554	1,682	6,554	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	4,501	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	38	38	518	38	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	642	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	1,547	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	544	544	4,424	544	0	90.00
91.00	09100	EMERGENCY	0	0	43,014	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	334,003	315,494	513,151	294,312	71,491	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER	7,520	7,520	1,653	7,520	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	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)	3	2,508,581	578,069	3,234,875	2,669,549	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000009	7.766168	1.122891	10.717469	37.341050	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/28/2018 10:50 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY POUNDS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED))	
			6.00	7.00	8.00	9.00	10.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	0	539,364	65,862	644,501	614,465	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	1.669785	0.127936	2.135297	8.594998	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: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/28/2018 10:50 am

		Cost Center Description	CAFETERIA (MEALS SERVED))	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRS G HRS))	CENTRAL SERVICES & SUPPLY (SUPPLY EXPENSE)	PHARMACY (COSTED REQUIS))	
			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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING,RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	83,845					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	1,213	0	288,197			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	433	0	10	4,501,379		14.00
15.00	01500	PHARMACY	2,387	0	0	0	3,150,175	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	146	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,637	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	13,957	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	2,398	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	373	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,227	0	152,168	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,588	0	24,513	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	916	0	5,797	0	0	41.00
43.00	04300	NURSERY	2,352	0	14,174	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	2,781	0	12,141	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,744	0	38,083	0	0	50.00
51.00	05100	RECOVERY ROOM	658	0	5,545	0	0	51.00
53.00	05300	ANESTHESIOLOGY	257	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,097	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,667	0	2,227	0	0	55.00
57.00	05700	CT SCAN	486	0	0	0	0	57.00
58.00	05800	MRI	384	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,338	0	6,818	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,484	0	9	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,507	0	151	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	553	0	179	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	95	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,325,393	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,175,986	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,150,175	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	108	0	892	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	678	0	279	0	0	90.00
91.00	09100	EMERGENCY	3,117	0	21,813	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	375	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	79,956	0	284,799	4,501,379	3,150,175	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER	3,889	0	3,398	0	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	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)	951,501	0	1,253,265	589,867	2,397,952	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/28/2018 10:50 am

		Cost Center Description	CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRS G HRS))	CENTRAL SERVICES & SUPPLY (SUPPLY EXPENSE)	PHARMACY (COSTED REQUIS))	
			11.00	12.00	13.00	14.00	15.00	
203.00		Unit cost multiplier (Wkst. B, Part I)	11.348333	0.000000	4.348640	0.131041	0.761212	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	70,305	0	138,260	79,034	326,778	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.838512	0.000000	0.479741	0.017558	0.103733	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: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/28/2018 10:50 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME))	
			16.00	17.00	19.00	20.00	21.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING, RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	466,558,041					16.00
17.00	01700	SOCIAL SERVICE	0	30,497				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			37,008	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	78,573,218	23,686	0	0	27,866	30.00
31.00	03100	INTENSIVE CARE UNIT	8,669,152	1,461	0	0	2,390	31.00
41.00	04100	SUBPROVIDER - IRF	1,945,404	738	0	0	0	41.00
43.00	04300	NURSERY	9,645,377	1,170	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	4,010,147	3,442	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	67,670,037	0	0	0	3,973	50.00
51.00	05100	RECOVERY ROOM	7,829,405	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	13,775,001	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,569,262	0	0	0	743	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	10,741,196	0	0	0	0	55.00
57.00	05700	CT SCAN	16,280,666	0	0	0	0	57.00
58.00	05800	MRI	7,961,407	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,609,430	0	0	0	0	59.00
60.00	06000	LABORATORY	43,581,369	0	0	0	15	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,430,962	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	7,221,573	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	4,958,387	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	14,263,513	0	0	0	294	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,183,168	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	26,492,591	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,654,088	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	54,618,150	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,177,588	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	408,100	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,690,117	0	0	0	26	90.00
91.00	09100	EMERGENCY	22,980,412	0	0	0	1,701	91.00
91.01	09101	PARTIAL HOSPITALIZATION	618,321	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	466,558,041	30,497	0	0	37,008	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER	0	0	0	0	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/28/2018 10:50 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME))	
			16.00	17.00	19.00	20.00	21.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	1,632,103	1,588,462	0	0	8,731,023	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.003498	52.085845	0.000000	0.000000	235.922584	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	287,699	117,715	0	0	645,120	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000617	3.859888	0.000000	0.000000	17.431907	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/28/2018 10:50 am

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME))	PARAMED ED PRGM (ASSIGNED TIME)		
			22.00	23.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00540	NONPATIENT TELEPHONES				5.01
5.02	00550	DATA PROCESSING				5.02
5.03	00560	PURCHASING,RECEIVING&STORES				5.03
5.04	00570	ADMITTING				5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE				5.05
5.06	00591	ADMINISTRATION & GENERAL				5.06
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
20.00	02000	NURSING SCHOOL				20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	37,008			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		100		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	27,866	0		30.00
31.00	03100	INTENSIVE CARE UNIT	2,390	0		31.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
43.00	04300	NURSERY	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	3,973	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	743	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	15	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	294	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	100		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	26	0		90.00
91.00	09100	EMERGENCY	1,701	0		91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	37,008	100		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	OTHER	0	0		194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0		194.01
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/28/2018 10:50 am

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME))	PARAMED ED PRGM (ASSIGNED TIME)	
			22.00	23.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	4,388,679	311,541	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	118.587305	3,115.410000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	399,325	24,464	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	10.790235	244.640000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/28/2018 10:50 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,604,156		29,604,156	88,028	29,692,184	30.00
31.00	03100	INTENSIVE CARE UNIT	3,720,814		3,720,814	0	3,720,814	31.00
41.00	04100	SUBPROVIDER - IRF	1,115,538		1,115,538	0	1,115,538	41.00
43.00	04300	NURSERY	2,482,631		2,482,631	0	2,482,631	43.00
44.00	04400	SKILLED NURSING FACILITY	3,473,162		3,473,162	0	3,473,162	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,683,928		14,683,928	0	14,683,928	50.00
51.00	05100	RECOVERY ROOM	804,813		804,813	0	804,813	51.00
53.00	05300	ANESTHESIOLOGY	411,760		411,760	0	411,760	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,262,550		4,262,550	0	4,262,550	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,204,581		2,204,581	0	2,204,581	55.00
57.00	05700	CT SCAN	704,599		704,599	0	704,599	57.00
58.00	05800	MRI	460,921		460,921	0	460,921	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,686,204		2,686,204	0	2,686,204	59.00
60.00	06000	LABORATORY	6,783,508		6,783,508	0	6,783,508	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	343,473		343,473	0	343,473	63.00
65.00	06500	RESPIRATORY THERAPY	1,694,715	0	1,694,715	0	1,694,715	65.00
66.00	06600	PHYSICAL THERAPY	2,737,226	0	2,737,226	0	2,737,226	66.00
69.00	06900	ELECTROCARDIOLOGY	537,539		537,539	0	537,539	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	75,248		75,248	0	75,248	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,341,715		4,341,715	0	4,341,715	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,015,317		4,015,317	0	4,015,317	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,391,156		8,391,156	0	8,391,156	73.00
74.00	07400	RENAL DIALYSIS	315,105		315,105	0	315,105	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	98,781		98,781	0	98,781	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	579,284		579,284	0	579,284	90.00
91.00	09100	EMERGENCY	3,030,901		3,030,901	0	3,030,901	91.00
91.01	09101	PARTIAL HOSPITALIZATION	284,467		284,467	0	284,467	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,422,478		2,422,478		2,422,478	92.00
200.00		Subtotal (see instructions)	102,266,570	0	102,266,570	88,028	102,354,598	200.00
201.00		Less Observation Beds	2,422,478		2,422,478		2,422,478	201.00
202.00		Total (see instructions)	99,844,092	0	99,844,092	88,028	99,932,120	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/28/2018 10:50 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	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	70,752,084		70,752,084			30.00
31.00	03100	INTENSIVE CARE UNIT	8,669,152		8,669,152			31.00
41.00	04100	SUBPROVIDER - IRF	1,945,404		1,945,404			41.00
43.00	04300	NURSERY	9,645,377		9,645,377			43.00
44.00	04400	SKILLED NURSING FACILITY	4,010,147		4,010,147			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,175,130	44,494,907	67,670,037	0.216993	0.000000	50.00
51.00	05100	RECOVERY ROOM	3,666,907	4,162,498	7,829,405	0.102794	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	4,913,201	8,861,800	13,775,001	0.029892	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,691,984	21,877,278	28,569,262	0.149201	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	393,730	10,347,466	10,741,196	0.205245	0.000000	55.00
57.00	05700	CT SCAN	5,698,287	10,582,379	16,280,666	0.043278	0.000000	57.00
58.00	05800	MRI	1,683,537	6,277,870	7,961,407	0.057894	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,914,150	3,695,280	9,609,430	0.279538	0.000000	59.00
60.00	06000	LABORATORY	23,638,215	19,943,154	43,581,369	0.155652	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,179,587	251,375	1,430,962	0.240029	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	6,690,016	531,557	7,221,573	0.234674	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,179,043	779,344	4,958,387	0.552040	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	6,519,367	7,744,146	14,263,513	0.037686	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	256,915	926,253	1,183,168	0.063599	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,335,640	13,156,951	26,492,591	0.163884	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,737,390	7,916,698	20,654,088	0.194408	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	40,443,589	14,174,561	54,618,150	0.153633	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,014,436	163,152	1,177,588	0.267585	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	408,100	408,100	0.242051	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	85,570	1,604,547	1,690,117	0.342748	0.000000	90.00
91.00	09100	EMERGENCY	8,460,939	14,519,473	22,980,412	0.131891	0.000000	91.00
91.01	09101	PARTIAL HOSPITALIZATION	3,066	615,255	618,321	0.460064	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,430,661	6,390,473	7,821,134	0.309735	0.000000	92.00
200.00		Subtotal (see instructions)	267,133,524	199,424,517	466,558,041			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	267,133,524	199,424,517	466,558,041			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet C Part I | Date/Time Prepared: 11/28/2018 10:50 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
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.216993	50.00
51.00	05100	RECOVERY ROOM	0.102794	51.00
53.00	05300	ANESTHESIOLOGY	0.029892	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.149201	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.205245	55.00
57.00	05700	CT SCAN	0.043278	57.00
58.00	05800	MRI	0.057894	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.279538	59.00
60.00	06000	LABORATORY	0.155652	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.240029	63.00
65.00	06500	RESPIRATORY THERAPY	0.234674	65.00
66.00	06600	PHYSICAL THERAPY	0.552040	66.00
69.00	06900	ELECTROCARDIOLOGY	0.037686	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.063599	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.163884	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.194408	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.153633	73.00
74.00	07400	RENAL DIALYSIS	0.267585	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0.242051	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	76.98
76.99	07699	LITHOTRIPSY	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.342748	90.00
91.00	09100	EMERGENCY	0.131891	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.460064	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.309735	92.00
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: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet C Part I | Date/Time Prepared: 11/28/2018 10:50 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	29,604,156		29,604,156	88,028	29,692,184	30.00
31.00	03100	INTENSIVE CARE UNIT	3,720,814		3,720,814	0	3,720,814	31.00
41.00	04100	SUBPROVIDER - IRF	1,115,538		1,115,538	0	1,115,538	41.00
43.00	04300	NURSERY	2,482,631		2,482,631	0	2,482,631	43.00
44.00	04400	SKILLED NURSING FACILITY	3,473,162		3,473,162	0	3,473,162	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,683,928		14,683,928	0	14,683,928	50.00
51.00	05100	RECOVERY ROOM	804,813		804,813	0	804,813	51.00
53.00	05300	ANESTHESIOLOGY	411,760		411,760	0	411,760	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,262,550		4,262,550	0	4,262,550	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,204,581		2,204,581	0	2,204,581	55.00
57.00	05700	CT SCAN	704,599		704,599	0	704,599	57.00
58.00	05800	MRI	460,921		460,921	0	460,921	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,686,204		2,686,204	0	2,686,204	59.00
60.00	06000	LABORATORY	6,783,508		6,783,508	0	6,783,508	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	343,473		343,473	0	343,473	63.00
65.00	06500	RESPIRATORY THERAPY	1,694,715	0	1,694,715	0	1,694,715	65.00
66.00	06600	PHYSICAL THERAPY	2,737,226	0	2,737,226	0	2,737,226	66.00
69.00	06900	ELECTROCARDIOLOGY	537,539		537,539	0	537,539	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	75,248		75,248	0	75,248	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,341,715		4,341,715	0	4,341,715	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,015,317		4,015,317	0	4,015,317	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,391,156		8,391,156	0	8,391,156	73.00
74.00	07400	RENAL DIALYSIS	315,105		315,105	0	315,105	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	98,781		98,781	0	98,781	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	579,284		579,284	0	579,284	90.00
91.00	09100	EMERGENCY	3,030,901		3,030,901	0	3,030,901	91.00
91.01	09101	PARTIAL HOSPITALIZATION	284,467		284,467	0	284,467	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,422,478		2,422,478		2,422,478	92.00
200.00		Subtotal (see instructions)	102,266,570	0	102,266,570	88,028	102,354,598	200.00
201.00		Less Observation Beds	2,422,478		2,422,478		2,422,478	201.00
202.00		Total (see instructions)	99,844,092	0	99,844,092	88,028	99,932,120	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/28/2018 10:50 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	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	70,752,084		70,752,084			30.00
31.00	03100	INTENSIVE CARE UNIT	8,669,152		8,669,152			31.00
41.00	04100	SUBPROVIDER - IRF	1,945,404		1,945,404			41.00
43.00	04300	NURSERY	9,645,377		9,645,377			43.00
44.00	04400	SKILLED NURSING FACILITY	4,010,147		4,010,147			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,175,130	44,494,907	67,670,037	0.216993	0.000000	50.00
51.00	05100	RECOVERY ROOM	3,666,907	4,162,498	7,829,405	0.102794	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	4,913,201	8,861,800	13,775,001	0.029892	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,691,984	21,877,278	28,569,262	0.149201	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	393,730	10,347,466	10,741,196	0.205245	0.000000	55.00
57.00	05700	CT SCAN	5,698,287	10,582,379	16,280,666	0.043278	0.000000	57.00
58.00	05800	MRI	1,683,537	6,277,870	7,961,407	0.057894	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,914,150	3,695,280	9,609,430	0.279538	0.000000	59.00
60.00	06000	LABORATORY	23,638,215	19,943,154	43,581,369	0.155652	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,179,587	251,375	1,430,962	0.240029	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	6,690,016	531,557	7,221,573	0.234674	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,179,043	779,344	4,958,387	0.552040	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	6,519,367	7,744,146	14,263,513	0.037686	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	256,915	926,253	1,183,168	0.063599	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,335,640	13,156,951	26,492,591	0.163884	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,737,390	7,916,698	20,654,088	0.194408	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	40,443,589	14,174,561	54,618,150	0.153633	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,014,436	163,152	1,177,588	0.267585	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	408,100	408,100	0.242051	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	85,570	1,604,547	1,690,117	0.342748	0.000000	90.00
91.00	09100	EMERGENCY	8,460,939	14,519,473	22,980,412	0.131891	0.000000	91.00
91.01	09101	PARTIAL HOSPITALIZATION	3,066	615,255	618,321	0.460064	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,430,661	6,390,473	7,821,134	0.309735	0.000000	92.00
200.00		Subtotal (see instructions)	267,133,524	199,424,517	466,558,041			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	267,133,524	199,424,517	466,558,041			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet C Part I | Date/Time Prepared: 11/28/2018 10:50 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
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	76.98
76.99	07699	LITHOTRIPSY	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
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: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet D Part I | Date/Time Prepared: 11/28/2018 10:50 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	5,135,570	0	5,135,570	25,286	203.10	30.00
31.00	INTENSIVE CARE UNIT	611,254		611,254	1,461	418.38	31.00
41.00	SUBPROVIDER - IRF	227,115	0	227,115	738	307.74	41.00
43.00	NURSERY	267,347		267,347	1,170	228.50	43.00
44.00	SKILLED NURSING FACILITY	647,826		647,826	3,442	188.21	44.00
200.00	Total (lines 30 through 199)	6,889,112		6,889,112	32,097		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	6,780	1,377,018	30.00
31.00	INTENSIVE CARE UNIT	849	355,205	31.00
41.00	SUBPROVIDER - IRF	358	110,171	41.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	2,746	516,825	44.00
200.00	Total (lines 30 through 199)	10,733	2,359,219	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet D Part II Date/Time Prepared: 11/28/2018 10:50 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	2,036,454	67,670,037	0.030094	6,796,824	204,544	50.00
51.00	05100	RECOVERY ROOM	108,311	7,829,405	0.013834	1,097,875	15,188	51.00
53.00	05300	ANESTHESIOLOGY	56,765	13,775,001	0.004121	1,278,360	5,268	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	785,059	28,569,262	0.027479	2,693,760	74,022	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	300,486	10,741,196	0.027975	202,147	5,655	55.00
57.00	05700	CT SCAN	91,511	16,280,666	0.005621	2,310,431	12,987	57.00
58.00	05800	MRI	55,385	7,961,407	0.006957	529,758	3,686	58.00
59.00	05900	CARDIAC CATHETERIZATION	419,038	9,609,430	0.043607	2,424,361	105,719	59.00
60.00	06000	LABORATORY	759,204	43,581,369	0.017420	9,052,966	157,703	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	25,899	1,430,962	0.018099	438,880	7,943	63.00
65.00	06500	RESPIRATORY THERAPY	199,251	7,221,573	0.027591	3,124,603	86,211	65.00
66.00	06600	PHYSICAL THERAPY	384,878	4,958,387	0.077622	1,116,000	86,626	66.00
69.00	06900	ELECTROCARDIOLOGY	48,054	14,263,513	0.003369	2,778,122	9,359	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,852	1,183,168	0.006636	99,008	657	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	348,773	26,492,591	0.013165	4,323,428	56,918	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	321,331	20,654,088	0.015558	5,228,114	81,339	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	766,511	54,618,150	0.014034	12,570,106	176,409	73.00
74.00	07400	RENAL DIALYSIS	23,711	1,177,588	0.020135	486,832	9,802	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	7,616	408,100	0.018662	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	56,470	1,690,117	0.033412	29,921	1,000	90.00
91.00	09100	EMERGENCY	241,682	22,980,412	0.010517	3,542,214	37,253	91.00
91.01	09101	PARTIAL HOSPITALIZATION	22,151	618,321	0.035824	2,605	93	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	418,992	7,821,134	0.053572	775,064	41,522	92.00
200.00		Total (lines 50 through 199)	7,485,384	371,535,877		60,901,379	1,179,904	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet D Part III Date/Time Prepared: 11/28/2018 10:50 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
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
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	25,286	0.00	6,780	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,461	0.00	849	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	738	0.00	358	41.00
43.00	04300	NURSERY		0	1,170	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	3,442	0.00	2,746	44.00
200.00		Total (lines 30 through 199)		0	32,097		10,733	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
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/28/2018 10:50 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	311,541	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	311,541	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/28/2018 10:50 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	67,670,037	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	7,829,405	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	13,775,001	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	28,569,262	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	10,741,196	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	16,280,666	0.000000	57.00
58.00	05800	MRI	0	0	0	7,961,407	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	9,609,430	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	43,581,369	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	1,430,962	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,221,573	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,958,387	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,263,513	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,183,168	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	26,492,591	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	20,654,088	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	311,541	311,541	54,618,150	0.005704	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,177,588	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	408,100	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	1,690,117	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	22,980,412	0.000000	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	618,321	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	7,821,134	0.000000	92.00
200.00		Total (lines 50 through 199)	0	311,541	311,541	371,535,877		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/28/2018 10:50 am

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	6,796,824	0	7,367,124	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	1,097,875	0	449,496	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	1,278,360	0	1,562,269	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,693,760	0	4,629,338	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	202,147	0	3,748,061	0	55.00
57.00	05700	CT SCAN	0.000000	2,310,431	0	3,243,105	0	57.00
58.00	05800	MRI	0.000000	529,758	0	1,398,116	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	2,424,361	0	1,445,153	0	59.00
60.00	06000	LABORATORY	0.000000	9,052,966	0	4,092,263	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	438,880	0	64,673	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	3,124,603	0	126,345	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,116,000	0	115,154	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,778,122	0	2,190,195	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	99,008	0	217,376	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	4,323,428	0	2,191,149	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	5,228,114	0	2,047,435	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.005704	12,570,106	71,700	2,979,812	16,997	73.00
74.00	07400	RENAL DIALYSIS	0.000000	486,832	0	96,408	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	168,434	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	29,921	0	477,141	0	90.00
91.00	09100	EMERGENCY	0.000000	3,542,214	0	3,065,475	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.000000	2,605	0	194,190	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	775,064	0	2,172,635	0	92.00
200.00		Total (lines 50 through 199)		60,901,379	71,700	44,041,347	16,997	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0224

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

Worksheet D Part V

Date/Time Prepared: 11/28/2018 10:50 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	0.216993	7,367,124	0	1,280	1,598,614	50.00
51.00	05100	RECOVERY ROOM	0.102794	449,496	0	0	46,205	51.00
53.00	05300	ANESTHESIOLOGY	0.029892	1,562,269	0	0	46,699	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.149201	4,629,338	0	42	690,702	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.205245	3,748,061	0	1,234	769,271	55.00
57.00	05700	CT SCAN	0.043278	3,243,105	0	1,141	140,355	57.00
58.00	05800	MRI	0.057894	1,398,116	0	336	80,943	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.279538	1,445,153	0	198	403,975	59.00
60.00	06000	LABORATORY	0.155652	4,092,263	0	0	636,969	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.240029	64,673	0	0	15,523	63.00
65.00	06500	RESPIRATORY THERAPY	0.234674	126,345	0	0	29,650	65.00
66.00	06600	PHYSICAL THERAPY	0.552040	115,154	0	0	63,570	66.00
69.00	06900	ELECTROCARDIOLOGY	0.037686	2,190,195	0	0	82,540	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.063599	217,376	0	0	13,825	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.163884	2,191,149	0	0	359,094	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.194408	2,047,435	0	0	398,038	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.153633	2,979,812	0	11,382	457,797	73.00
74.00	07400	RENAL DIALYSIS	0.267585	96,408	0	0	25,797	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.242051	168,434	0	0	40,770	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.342748	477,141	0	169	163,539	90.00
91.00	09100	EMERGENCY	0.131891	3,065,475	0	0	404,309	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.460064	194,190	0	0	89,340	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.309735	2,172,635	0	0	672,941	92.00
200.00		Subtotal (see instructions)		44,041,347	0	15,782	7,230,466	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		44,041,347	0	15,782	7,230,466	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/28/2018 10:50 am

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		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	278	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	253	55.00
57.00	05700	CT SCAN	0	49	57.00
58.00	05800	MRI	0	19	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	55	59.00
60.00	06000	LABORATORY	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,749	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	58	90.00
91.00	09100	EMERGENCY	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	2,467	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	2,467	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0224 | Component CCN: 14-T224

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

Worksheet D Part II | Date/Time Prepared: 11/28/2018 10:50 am

Title XVIII | Subprovider - IRF | 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	2,036,454	67,670,037	0.030094	0	0	50.00
51.00	05100	RECOVERY ROOM	108,311	7,829,405	0.013834	0	0	51.00
53.00	05300	ANESTHESIOLOGY	56,765	13,775,001	0.004121	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	785,059	28,569,262	0.027479	13,037	358	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	300,486	10,741,196	0.027975	0	0	55.00
57.00	05700	CT SCAN	91,511	16,280,666	0.005621	7,656	43	57.00
58.00	05800	MRI	55,385	7,961,407	0.006957	5,702	40	58.00
59.00	05900	CARDIAC CATHETERIZATION	419,038	9,609,430	0.043607	0	0	59.00
60.00	06000	LABORATORY	759,204	43,581,369	0.017420	148,880	2,593	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	25,899	1,430,962	0.018099	3,523	64	63.00
65.00	06500	RESPIRATORY THERAPY	199,251	7,221,573	0.027591	20,384	562	65.00
66.00	06600	PHYSICAL THERAPY	384,878	4,958,387	0.077622	533,977	41,448	66.00
69.00	06900	ELECTROCARDIOLOGY	48,054	14,263,513	0.003369	4,240	14	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,852	1,183,168	0.006636	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	348,773	26,492,591	0.013165	7,013	92	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	321,331	20,654,088	0.015558	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	766,511	54,618,150	0.014034	245,318	3,443	73.00
74.00	07400	RENAL DIALYSIS	23,711	1,177,588	0.020135	48,204	971	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	7,616	408,100	0.018662	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	56,470	1,690,117	0.033412	0	0	90.00
91.00	09100	EMERGENCY	241,682	22,980,412	0.010517	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	22,151	618,321	0.035824	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	7,821,134	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	7,066,392	371,535,877		1,037,934	49,628	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0224 | Component CCN: 14-T224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/28/2018 10:50 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	311,541	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	311,541	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0224 | Component CCN: 14-T224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/28/2018 10:50 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	67,670,037	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	7,829,405	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	13,775,001	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	28,569,262	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	10,741,196	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	16,280,666	0.000000	57.00
58.00	05800	MRI	0	0	0	7,961,407	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	9,609,430	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	43,581,369	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	1,430,962	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,221,573	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,958,387	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,263,513	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,183,168	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	26,492,591	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	20,654,088	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	311,541	311,541	54,618,150	0.005704	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,177,588	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	408,100	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	1,690,117	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	22,980,412	0.000000	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	618,321	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	7,821,134	0.000000	92.00
200.00		Total (lines 50 through 199)	0	311,541	311,541	371,535,877		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0224 | Component CCN: 14-T224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/28/2018 10:50 am

Title XVIII | Subprovider - IRF | 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	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	13,037	0	16,860	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
57.00	05700	CT SCAN	0.000000	7,656	0	0	0	57.00
58.00	05800	MRI	0.000000	5,702	0	10	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	148,880	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	3,523	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	20,384	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	533,977	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	4,240	0	462	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	7,013	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.005704	245,318	1,399	720	4	73.00
74.00	07400	RENAL DIALYSIS	0.000000	48,204	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.000000	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,037,934	1,399	18,052	4	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0224 | Component CCN: 14-T224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet D Part V | Date/Time Prepared: 11/28/2018 10:50 am

Title XVIII | Subprovider - IRF | 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	0.216993	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.102794	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.029892	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.149201	16,860	0	0	2,516	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.205245	0	0	0	0	55.00
57.00	05700	CT SCAN	0.043278	0	0	0	0	57.00
58.00	05800	MRI	0.057894	10	0	0	1	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.279538	0	0	0	0	59.00
60.00	06000	LABORATORY	0.155652	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.240029	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.234674	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.552040	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.037686	462	0	0	17	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.063599	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.163884	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.194408	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.153633	720	0	0	111	73.00
74.00	07400	RENAL DIALYSIS	0.267585	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.242051	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.342748	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.131891	0	0	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.460064	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.309735	0	0	0	0	92.00
200.00		Subtotal (see instructions)		18,052	0	0	2,645	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		18,052	0	0	2,645	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0224 Component CCN: 14-T224	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part V Date/Time Prepared: 11/28/2018 10:50 am
	Title XVIII	Subprovider - IRF	PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0224 | Component CCN: 14-5568 | Period: From 01/01/2018 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/28/2018 10:50 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	311,541	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	311,541	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0224 | Component CCN: 14-5568 | Period: From 01/01/2018 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/28/2018 10:50 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	67,670,037	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	7,829,405	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	13,775,001	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	28,569,262	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	10,741,196	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	16,280,666	0.000000	57.00
58.00	05800	MRI	0	0	0	7,961,407	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	9,609,430	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	43,581,369	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	1,430,962	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,221,573	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,958,387	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,263,513	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,183,168	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	26,492,591	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	20,654,088	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	311,541	311,541	54,618,150	0.005704	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,177,588	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	408,100	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	1,690,117	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	22,980,412	0.000000	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	618,321	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	7,821,134	0.000000	92.00
200.00		Total (lines 50 through 199)	0	311,541	311,541	371,535,877		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0224 | Component CCN: 14-5568 | Period: From 01/01/2018 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/28/2018 10:50 am

Title XVIII | Skilled Nursing Facility | 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	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	45,286	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	304,419	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	626,432	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	293,128	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.005704	1,372,008	7,826	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.000000	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		2,641,273	7,826	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0224 | Component CCN: 14-5568 | Period: From 01/01/2018 To 06/30/2018 | Worksheet D Part V | Date/Time Prepared: 11/28/2018 10:50 am

Title XVIII | Skilled Nursing Facility | 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	0.216993	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.102794	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.029892	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.149201	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.205245	0	0	0	0	55.00
57.00	05700	CT SCAN	0.043278	0	0	0	0	57.00
58.00	05800	MRI	0.057894	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.279538	0	0	0	0	59.00
60.00	06000	LABORATORY	0.155652	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.240029	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.234674	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.552040	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.037686	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.063599	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.163884	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.194408	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.153633	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.267585	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.242051	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.342748	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.131891	0	0	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.460064	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.309735	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0224 | Component CCN: 14-5568 | Period: From 01/01/2018 To 06/30/2018 | Worksheet D Part V | Date/Time Prepared: 11/28/2018 10:50 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
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: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/28/2018 10:50 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)	25,286	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	25,286	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)	23,223	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	6,780	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)	29,692,184	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)	29,692,184	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)	29,692,184	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)	1,174.25	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	7,961,415	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)	7,961,415	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/28/2018 10:50 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	3,720,814	1,461	2,546.76	849	2,162,199	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)	10,357,567	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	20,481,181	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)	1,732,223	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,251,604	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,983,827	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	17,497,354	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)	2,063	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,174.25	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,422,478	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0224	Period: From 01/01/2018 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/28/2018 10:50 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	5,135,570	29,692,184	0.172960	2,422,478	418,992	90.00
91.00	Nursing School cost	0	29,692,184	0.000000	2,422,478	0	91.00
92.00	Allied health cost	0	29,692,184	0.000000	2,422,478	0	92.00
93.00	All other Medical Education	0	29,692,184	0.000000	2,422,478	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0224 | Component CCN: 14-T224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/28/2018 10:50 am

Title XVIII | Subprovider - IRF | 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)	738	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	738	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)	738	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)	358	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)	1,115,538	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)	1,115,538	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)	1,115,538	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)	1,511.57	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	541,142	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)	541,142	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0224 | Component CCN: 14-T224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/28/2018 10:50 am

Title XVIII | Subprovider - IRF | 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	0	0	0.00	0	0	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)	378,083	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	919,225	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)	110,171	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	51,027	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	161,198	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	758,027	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet D-1

Component CCN: 14-T224 | Date/Time Prepared: 11/28/2018 10:50 am

Title XVIII | Subprovider - IRF | 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	227,115	1,115,538	0.203592	0	0	90.00
91.00	Nursing School cost	0	1,115,538	0.000000	0	0	91.00
92.00	Allied health cost	0	1,115,538	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,115,538	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0224 | Component CCN: 14-5568 | Period: From 01/01/2018 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/28/2018 10:50 am

Title XVIII | Skilled Nursing Facility | 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)	3,442	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,442	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,442	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,746	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)	3,473,162	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)	3,473,162	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)	3,473,162	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0224 | Component CCN: 14-5568 | Period: From 01/01/2018 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/28/2018 10:50 am

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	3,473,162	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	1,009.05	71.00
72.00	Program routine service cost (line 9 x line 71)	2,770,851	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	2,770,851	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	2,770,851	83.00
84.00	Program inpatient ancillary services (see instructions)	683,129	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	3,453,980	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0224 | Component CCN: 14-5568 | Period: From 01/01/2018 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/28/2018 10:50 am

Title XVIII | Skilled Nursing Facility | 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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/28/2018 10:50 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)	25,286	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	25,286	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)	23,223	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)	891	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	1,170	15.00
16.00	Nursery days (title V or XIX only)	437	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)	29,604,156	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)	29,604,156	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)	29,604,156	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)	1,170.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,043,156	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)	1,043,156	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/28/2018 10:50 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)	2,482,631	1,170	2,121.91	437	927,275	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,720,814	1,461	2,546.76	103	262,316	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)	2,232,747	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)	2,063	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,170.77	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,415,299	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/28/2018 10:50 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	5,135,570	29,604,156	0.173475	2,415,299	418,994	90.00
91.00	Nursing School cost	0	29,604,156	0.000000	2,415,299	0	91.00
92.00	Allied health cost	0	29,604,156	0.000000	2,415,299	0	92.00
93.00	All other Medical Education	0	29,604,156	0.000000	2,415,299	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0224 | Component CCN: 14-T224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/28/2018 10:50 am

Title XIX | Subprovider - IRF | 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)	738	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	738	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)	738	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)	58	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	1,170	15.00
16.00	Nursery days (title V or XIX only)	437	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)	1,115,538	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)	1,115,538	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)	1,115,538	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)	1,511.57	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	87,671	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)	87,671	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0224 | Component CCN: 14-T224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/28/2018 10:50 am

Title XIX | Subprovider - IRF | 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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	87,671	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)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet D-1

Component CCN: 14-T224 | Date/Time Prepared: 11/28/2018 10:50 am

Title XIX | Subprovider - IRF | 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	227,115	1,115,538	0.203592	0	0	90.00
91.00	Nursing School cost	0	1,115,538	0.000000	0	0	91.00
92.00	Allied health cost	0	1,115,538	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,115,538	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/28/2018 10:50 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		20,984,593		30.00
31.00	03100	INTENSIVE CARE UNIT		3,721,399		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.216993	6,796,824	1,474,863	50.00
51.00	05100	RECOVERY ROOM	0.102794	1,097,875	112,855	51.00
53.00	05300	ANESTHESIOLOGY	0.029892	1,278,360	38,213	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.149201	2,693,760	401,912	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.205245	202,147	41,490	55.00
57.00	05700	CT SCAN	0.043278	2,310,431	99,991	57.00
58.00	05800	MRI	0.057894	529,758	30,670	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.279538	2,424,361	677,701	59.00
60.00	06000	LABORATORY	0.155652	9,052,966	1,409,112	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.240029	438,880	105,344	63.00
65.00	06500	RESPIRATORY THERAPY	0.234674	3,124,603	733,263	65.00
66.00	06600	PHYSICAL THERAPY	0.552040	1,116,000	616,077	66.00
69.00	06900	ELECTROCARDIOLOGY	0.037686	2,778,122	104,696	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.063599	99,008	6,297	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.163884	4,323,428	708,541	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.194408	5,228,114	1,016,387	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.153633	12,570,106	1,931,183	73.00
74.00	07400	RENAL DIALYSIS	0.267585	486,832	130,269	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.242051	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.342748	29,921	10,255	90.00
91.00	09100	EMERGENCY	0.131891	3,542,214	467,186	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.460064	2,605	1,198	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.309735	775,064	240,064	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		60,901,379	10,357,567	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)		60,901,379		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 14-0224 Component CCN: 14-T224	Period: From 01/01/2018 To 06/30/2018	Worksheet D-3 Date/Time Prepared: 11/28/2018 10:50 am
	Title XVIII	Subprovider - IRF	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		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
41.00	04100	SUBPROVIDER - IRF		941,333		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.216993	0	0	50.00
51.00	05100	RECOVERY ROOM	0.102794	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.029892	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.149201	13,037	1,945	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.205245	0	0	55.00
57.00	05700	CT SCAN	0.043278	7,656	331	57.00
58.00	05800	MRI	0.057894	5,702	330	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.279538	0	0	59.00
60.00	06000	LABORATORY	0.155652	148,880	23,173	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.240029	3,523	846	63.00
65.00	06500	RESPIRATORY THERAPY	0.234674	20,384	4,784	65.00
66.00	06600	PHYSICAL THERAPY	0.552040	533,977	294,777	66.00
69.00	06900	ELECTROCARDIOLOGY	0.037686	4,240	160	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.063599	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.163884	7,013	1,149	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.194408	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.153633	245,318	37,689	73.00
74.00	07400	RENAL DIALYSIS	0.267585	48,204	12,899	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.242051	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.342748	0	0	90.00
91.00	09100	EMERGENCY	0.131891	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.460064	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.309735	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,037,934	378,083	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)		1,037,934		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet D-3

Component CCN: 14-5568 | Date/Time Prepared: 11/28/2018 10:50 am

Title XVIII | Skilled Nursing Facility | 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		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.216993	0	0	50.00
51.00	05100	RECOVERY ROOM	0.102794	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.029892	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.149201	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.205245	0	0	55.00
57.00	05700	CT SCAN	0.043278	0	0	57.00
58.00	05800	MRI	0.057894	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.279538	0	0	59.00
60.00	06000	LABORATORY	0.155652	45,286	7,049	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.240029	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.234674	304,419	71,439	65.00
66.00	06600	PHYSICAL THERAPY	0.552040	626,432	345,816	66.00
69.00	06900	ELECTROCARDIOLOGY	0.037686	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.063599	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.163884	293,128	48,039	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.194408	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.153633	1,372,008	210,786	73.00
74.00	07400	RENAL DIALYSIS	0.267585	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.242051	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.342748	0	0	90.00
91.00	09100	EMERGENCY	0.131891	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.460064	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.309735	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,641,273	683,129	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)		2,641,273		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet E Part A Date/Time Prepared: 11/28/2018 10:50 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)		12,869,720	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		0	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)		187,274	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		4,132,938	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		265.84	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)		139.15	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		22.76	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.		0.64	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).		-17.14	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)		7.00	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)		105.61	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		104.54	10.00
11.00	FTE count for residents in dental and podiatric programs.		13.19	11.00
12.00	Current year allowable FTE (see instructions)		117.73	12.00
13.00	Total allowable FTE count for the prior year.		121.28	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.		120.88	14.00
15.00	Sum of lines 12 through 14 divided by 3.		119.96	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		119.96	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.451249	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.458422	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.451249	21.00
22.00	IME payment adjustment (see instructions)		2,828,520	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		908,341	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)		-1.07	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)		2,828,520	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		908,341	29.01
	Disproportionate Share Adjustment			
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		8.68	30.00
31.00	Percentage of Medicaid patient days (see instructions)		17.08	31.00
32.00	Sum of lines 30 and 31		25.76	32.00
33.00	Allowable disproportionate share percentage (see instructions)		10.47	33.00
34.00	Disproportionate share adjustment (see instructions)		336,865	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet E Part A | Date/Time Prepared: 11/28/2018 10:50 am

Title XVIII | Hospital | PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,860,774	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	922,739	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	922,739		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
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	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		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	17,145,118		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)	18,053,459	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,449,160	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	2,387,465	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	71,700	58.00
59.00	Total (sum of amounts on lines 49 through 58)	21,961,784	59.00
60.00	Primary payer payments	85,067	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	21,876,717	61.00
62.00	Deductibles billed to program beneficiaries	1,362,036	62.00
63.00	Coinsurance billed to program beneficiaries	102,785	63.00
64.00	Allowable bad debts (see instructions)	127,414	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	82,819	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	38,336	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	20,494,715	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)	106,859	70.93
70.94	HRR adjustment amount (see instructions)	-164,734	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet E Part A Date/Time Prepared: 11/28/2018 10:50 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)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		20,436,840	71.00
71.01	Sequestration adjustment (see instructions)		408,737	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		20,092,081	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)		-63,978	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		332,987	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/28/2018 10:50 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	12,869,720	0	12,869,720		12,869,720	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0	0		0	0	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	187,274	0	187,274	0	187,274	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	4,132,938	0	4,132,938	0	4,132,938	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.451249	0.451249	0.451249	0.451249		5.00
6.00	IME payment adjustment (see instructions)	22.00	2,828,520	0	2,828,520	0	2,828,520	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	908,341	0	908,341	0	908,341	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	2,828,520	0	2,828,520	0	2,828,520	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	908,341	0	908,341	0	908,341	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1047	0.1047	0.1047	0.1047		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	336,865	0	336,865	0	336,865	11.00
11.01	Uncompensated care payments	36.00	922,739	0	2,560,008	0	2,560,008	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	17,145,118	0	17,145,118	0	17,145,118	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	18,053,459	0	18,053,459	0	18,053,459	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,449,160	0	1,449,160	0	1,449,160	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	19,502,619	0	19,502,619	19.00

LOW VOLUME CALCULATION EXHIBIT 4	Provider CCN: 14-0224	Period: From 01/01/2018 To 06/30/2018	Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/28/2018 10:50 am
	Title XVIII	Hospital	PPS

		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,048,175	0	1,048,175	0	1,048,175	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	54,039	0	54,039	0	54,039	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	0.2774	0.2774	0.2774	0.2774		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	290,764	0	290,764	0	290,764	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0536	0.0536	0.0536	0.0536		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	56,182	0	56,182	0	56,182	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,449,160	0	1,449,160	0	1,449,160	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: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/28/2018 10:50 am

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	12,869,720	12,869,720		12,869,720	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0		0	0	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	187,274	187,274	0	187,274	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	4,132,938	4,132,938	0	4,132,938	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.451249	0.451249	0.451249		5.00
6.00	IME payment adjustment (see instructions)	22.00	2,828,520	2,828,520	0	2,828,520	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	908,341	908,341	0	908,341	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	2,828,520	2,828,520	0	2,828,520	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	908,341	908,341	0	908,341	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1047	0.1047	0.1047		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	336,865	336,865	0	336,865	11.00
11.01	Uncompensated care payments	36.00	922,739	922,739	0	922,739	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	17,145,118	17,145,118	0	17,145,118	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	18,053,459	18,053,459	0	18,053,459	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,449,160	1,449,160	0	1,449,160	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			19,502,619	0	19,502,619	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/28/2018 10:50 am

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,048,175	1,048,175	0	1,048,175	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	54,039	54,039	0	54,039	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	0.2774	0.2774	0.2774		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	290,764	290,764	0	290,764	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0536	0.0536	0.0536		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	56,182	56,182	0	56,182	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,449,160	1,449,160	0	1,449,160	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	106,859	106,859	0	106,859	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	-164,734	-164,734	0	-164,734	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet E Part B Date/Time Prepared: 11/28/2018 10:50 am

	Title XVIII	Hospital	PPS	

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	2,467	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	7,213,469	2.00
3.00	OPPS payments	5,519,427	3.00
4.00	Outlier payment (see instructions)	70,148	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	16,997	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	2,467	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	15,782	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)	15,782	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)	15,782	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	13,315	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)	2,467	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)	5,606,572	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,089,991	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)	4,519,048	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	674,452	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)	5,193,500	30.00
31.00	Primary payer payments	1,020	31.00
32.00	Subtotal (line 30 minus line 31)	5,192,480	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)	40,643	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	26,418	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	7,259	36.00
37.00	Subtotal (see instructions)	5,218,898	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	5,218,898	40.00
40.01	Sequestration adjustment (see instructions)	104,378	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	5,147,885	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-33,365	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

	Provider CCN: 14-0224 Component CCN: 14-T224	Period: From 01/01/2018 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/28/2018 10:50 am
	Title XVIII	Subprovider - IRF	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)	2,641	2.00
3.00	OPPS payments	2,141	3.00
4.00	Outlier payment (see instructions)	0	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	4	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)	2,145	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	443	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,702	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,702	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	1,702	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	1,702	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,702	40.00
40.01	Sequestration adjustment (see instructions)	34	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	1,664	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	4	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0224 | Component CCN: 14-5568 | Period: From 01/01/2018 To 06/30/2018 | Worksheet E Part B | Date/Time Prepared: 11/28/2018 10:50 am

Title XVIII | Skilled Nursing Facility | 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)	0	2.00
3.00	OPPS payments		3.00
4.00	Outlier payment (see instructions)		4.00
4.01	Outlier reconciliation amount (see instructions)		4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		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)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		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)	0	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	0	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	0	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	0	37.00
38.00	MSP-LCC reconciliation amount from PS&R		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)	0	40.00
40.01	Sequestration adjustment (see instructions)	0	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	0	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet E-1 Part I Date/Time Prepared: 11/28/2018 10:50 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		17,643,293		4,410,892	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		2,448,788		736,993	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		20,092,081		5,147,885	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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		63,978		33,365	6.02
7.00	Total Medicare program liability (see instructions)		20,028,103		5,114,520	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0224 | Component CCN: 14-T224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 11/28/2018 10:50 am

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		648,005		1,664	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	08/02/2016	19,329		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)		-19,329		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		628,676		1,664	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		25,002		4	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		653,678		1,668	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-0224 | Component CCN: 14-5568 | Period: From 01/01/2018 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 11/28/2018 10:50 am

Title XVIII | Skilled Nursing Facility | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,398,412		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,398,412		0	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		7,669		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,406,081		0	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: 14-0224	Period: From 01/01/2018 To 06/30/2018	Worksheet E-1 Part II Date/Time Prepared: 11/28/2018 10:50 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: 14-0224 | Component CCN: 14-T224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet E-3 Part III | Date/Time Prepared: 11/28/2018 10:50 am

Title XVIII | Subprovider - IRF | PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	559,535	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0000	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	42,021	3.00
4.00	Outlier Payments	63,355	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	4.077348	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	664,911	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	664,911	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	664,911	19.00
20.00	Deductibles	1,340	20.00
21.00	Subtotal (line 19 minus line 20)	663,571	21.00
22.00	Coinsurance	0	22.00
23.00	Subtotal (line 21 minus line 22)	663,571	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	3,150	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	2,048	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	3,150	26.00
27.00	Subtotal (sum of lines 23 and 25)	665,619	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	1,399	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	667,018	32.00
32.01	Sequestration adjustment (see instructions)	13,340	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	628,676	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	25,002	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	1,957	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	63,355	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

	Provider CCN: 14-0224 Component CCN: 14-5568	Period: From 01/01/2018 To 06/30/2018	Worksheet E-3 Part VI Date/Time Prepared: 11/28/2018 10:50 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	1,515,391	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	7,826	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,523,217	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	88,440	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	1,434,777	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Demonstration payment adjustment amount before sequestration	0	14.99
15.00	Subtotal (see instructions	1,434,777	15.00
15.01	Sequestration adjustment (see instructions)	28,696	15.01
15.02	Demonstration payment adjustment amount after sequestration	0	15.02
16.00	Interim payments	1,398,412	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)	7,669	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0224	Period: From 01/01/2018 To 06/30/2018	Worksheet E-3 Part VII Date/Time Prepared: 11/28/2018 10:50 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	2,232,747		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)	2,232,747	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)	2,232,747	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)	2,232,747	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)	2,232,747	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

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0224 | Component CCN: 14-T224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet E-3 Part VII | Date/Time Prepared: 11/28/2018 10:50 am

Title XIX | Subprovider - IRF | 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	87,671		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)	87,671	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)	87,671	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)	87,671	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)	87,671	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: 14-0224	Period: From 01/01/2018 To 06/30/2018	Worksheet E-4 Date/Time Prepared: 11/28/2018 10:50 am
	Title XVIII	Hospital	PPS

		1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT		
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.	70.63	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	11.71	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)	0.89	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))	-10.22	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)	3.47	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	51.28	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)	51.87	6.00
7.00	Enter the lesser of line 5 or line 6	51.28	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.	44.69	7.18	51.87	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.	44.18	7.10	51.28	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		6.54		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	44.18	13.64		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	46.74	12.74		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	45.39	12.54		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	45.44	12.97		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	45.44	12.97		17.00
18.00	Per resident amount	135,014.86	130,140.11		18.00
19.00	Approved amount for resident costs	6,135,075	1,687,917	7,822,992	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)	0.59	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)	7,822,992	25.00

		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions)	7,987	2,443		26.00
27.00	Total Inpatient Days (see instructions)	25,766	25,766		27.00
28.00	Ratio of inpatient days to total inpatient days	0.309982	0.094815		28.00
29.00	Program direct GME amount	2,424,987	741,737		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		104,807		30.00
31.00	Net Program direct GME amount			3,061,917	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 14-0224	Period: From 01/01/2018 To 06/30/2018	Worksheet E-4 Date/Time Prepared: 11/28/2018 10:50 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)	1,177,588	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)	25,694,474	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)	85,067	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	25,609,407	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	7,235,578	42.00
43.00	Primary payer payments (see instructions)	1,020	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	7,234,558	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	32,843,965	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.779729	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.220271	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	3,061,917	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	2,387,465	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	674,452	50.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet G Date/Time Prepared: 11/28/2018 10:50 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	19,615	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	100,571,461	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-67,185,964	0	0	0	6.00
7.00	Inventory	5,887,640	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	1,638,504	0	0	0	9.00
10.00	Due from other funds	-1,216,235	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	39,715,021	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	26,070,000	0	0	0	12.00
13.00	Land improvements	407,464	0	0	0	13.00
14.00	Accumulated depreciation	-17,859	0	0	0	14.00
15.00	Buildings	63,011,262	0	0	0	15.00
16.00	Accumulated depreciation	-768,557	0	0	0	16.00
17.00	Leasehold improvements	2,484,822	0	0	0	17.00
18.00	Accumulated depreciation	-47,330	0	0	0	18.00
19.00	Fixed equipment	4,817,932	0	0	0	19.00
20.00	Accumulated depreciation	-290,171	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	12,320,510	0	0	0	23.00
24.00	Accumulated depreciation	-1,142,901	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)	106,845,172	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,427,242	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,427,242	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	147,987,435	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	7,491,444	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	3,535,059	0	0	0	43.00
44.00	Other current liabilities	28,354,284	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	39,380,787	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	15,913,872	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	15,913,872	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	55,294,659	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	92,692,776				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	92,692,776	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	147,987,435	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet G-1 | Date/Time Prepared: 11/28/2018 10:50 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		94,437,335		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,744,559				2.00
3.00	Total (sum of line 1 and line 2)		92,692,776		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00	TRANSFER FROM AFFILIATE	0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		92,692,776		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		92,692,776		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/28/2018 10:50 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	80,397,461		80,397,461	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	1,945,404		1,945,404	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	4,010,147		4,010,147	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	86,353,012		86,353,012	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	8,669,152		8,669,152	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)	8,669,152		8,669,152	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	95,022,164		95,022,164	17.00
18.00	Ancillary services	172,111,359	176,294,770	348,406,129	18.00
19.00	Outpatient services	0	23,129,748	23,129,748	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER MISC REVENUES	0	7,681,319	7,681,319	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	267,133,523	207,105,837	474,239,360	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		109,579,305		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00	RECONCILING ITEM	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)		109,579,305		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-0224 | Period: From 01/01/2018 To 06/30/2018 | Worksheet G-3 | Date/Time Prepared: 11/28/2018 10:50 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	474,239,360	1.00
2.00	Less contractual allowances and discounts on patients' accounts	369,500,489	2.00
3.00	Net patient revenues (line 1 minus line 2)	104,738,871	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	109,579,305	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,840,434	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	1,675	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	556,537	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	REVENUE FROM OTHER SOURCES	2,533,316	24.00
24.01	NET ASSETS RELEASED FROM RESTRICTION	4,347	24.01
25.00	Total other income (sum of lines 6-24)	3,095,875	25.00
26.00	Total (line 5 plus line 25)	-1,744,559	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,744,559	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0224	Period: From 01/01/2018 To 06/30/2018	Worksheet L Parts I-III Date/Time Prepared: 11/28/2018 10:50 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,048,175	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	54,039	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)	138.28	3.00
4.00	Number of interns & residents (see instructions)	119.96	4.00
5.00	Indirect medical education percentage (see instructions)	27.74	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)	290,764	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	8.68	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	17.08	8.00
9.00	Sum of lines 7 and 8	25.76	9.00
10.00	Allowable disproportionate share percentage (see instructions)	5.36	10.00
11.00	Disproportionate share adjustment (see instructions)	56,182	11.00
12.00	Total prospective capital payments (see instructions)	1,449,160	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