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: 14-0275	Period: From 07/01/2017 To 06/30/2018	Worksheet S Parts I-III Date/Time Prepared: 9/11/2018 11:15 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: — Time:
2. [ ] Manually submitted cost report
3. [1] 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. [5] 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 GENESIS MEDICAL CENTER - SILVIS (14-0275) for the cost reporting period beginning 07/01/2017 and ending 06/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

CFO
Title

Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	143,372	6,476	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	1	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
200.00	Total	0	143,373	6,476	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: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 9/11/2018 11:15 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 801 HOSPITAL ROAD	PO Box:			1.00
2.00	City: SILVIS	State: IL	Zip Code: 61282-	County: ROCK ISLAND	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	GENESIS MEDICAL CENTER - SILVIS	140275	19340	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	ILLINI RESTORATIVE CARE CENTER	145703	19340		09/03/1991	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)	07/01/2017	06/30/2018	20.00
21.00	Type of Control (see instructions)	2		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.	483	353	5	10	1,645	29	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 9/11/2018 11:15 am

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

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

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	N			60.00

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 9/11/2018 11:15 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0275	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 9/11/2018 11:15 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 9/11/2018 11:15 am

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

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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	161,267	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	H55790	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 9/11/2018 11:15 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: GENESIS HEALTH SYSTEM	Contractor's Name: WPS	Contractor's Number: 05001	141.00
142.00	Street: 1227 E. RUSHOLME STREET	PO Box:		142.00
143.00	City: DAVENPORT	State: IA	Zip Code: 52803	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.			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)	07/01/2017	06/30/2018	170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II Date/Time Prepared: 9/11/2018 11:15 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)	N			3.00

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	09/29/2016	Y	09/29/2016	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: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II Date/Time Prepared: 9/11/2018 11:15 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	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.			Y		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.	MARTIN		ORWITZ		41.00
42.00	Enter the employer/company name of the cost report preparer.	GENESIS HEALTH SYSTEM				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563-421-4175		ORWITZM@GENESISHEALTH.COM		43.00

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		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.	DIRECTOR, REIMBURSEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HFS Supplemental Information | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part IX Date/Time Prepared: 9/11/2018 11:15 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I Date/Time Prepared: 9/11/2018 11:15 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	138	50,370	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)		138	50,370	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	7	2,555	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)		145	52,925	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	92	33,580		0	19.00
20.00	NURSING FACILITY	45.00	28	10,220		0	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)		265				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

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	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	3,519	285	9,147			1.00
2.00	HMO and other (see instructions)	2,322	1,940				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,519	285	9,147			7.00
8.00	INTENSIVE CARE UNIT	356	31	902			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		269	833			13.00
14.00	Total (see instructions)	3,875	585	10,882	0.00	425.08	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	3,524	6,728	25,609	0.00	65.97	19.00
20.00	NURSING FACILITY		0	4,946	0.00	7.67	20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	498.72	27.00
28.00	Observation Bed Days		355	1,051			28.00
29.00	Ambulance Trips	3,009					29.00
30.00	Employee discount days (see instruction)			108			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 9/11/2018 11:15 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	1,313	841	3,712	1.00
2.00	HMO and other (see instructions)			784	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,313	841	3,712	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY	0.00					20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						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: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part II Date/Time Prepared: 9/11/2018 11:15 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	28,413,672	0	28,413,672	965,756.00	29.42	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	2,956,530	-21,150	2,935,380	139,750.00	21.00	9.00
10.00	Excluded area salaries (see instructions)		3,608,158	37,400	3,645,558	183,890.00	19.82	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		908,396	0	908,396	11,971.00	75.88	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		36,195	0	36,195	165.00	219.36	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		8,754,213	0	8,754,213	181,708.00	48.18	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)		4,265,142	0	4,265,142			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		987,763	0	987,763			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			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	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	1,159,015	0	1,159,015	19,290.00	60.08	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part II Date/Time Prepared: 9/11/2018 11:15 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		296,254	0	296,254	1,965.00	150.77	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	517,293	0	517,293	26,397.00	19.60	30.00
31.00	Laundry & Linen Service	8.00	53,155	-16,250	36,905	2,722.00	13.56	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		548,995	0	548,995	23,643.00	23.22	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		80,200	0	80,200	3,111.00	25.78	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	719,925	0	719,925	20,194.00	35.65	38.00
39.00	Central Services and Supply	14.00	130,576	0	130,576	8,884.00	14.70	39.00
40.00	Pharmacy	15.00	1,682,777	0	1,682,777	39,541.00	42.56	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part III Date/Time Prepared: 9/11/2018 11:15 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)		29,339,121	0	29,339,121	994,475.00	29.50	1.00
2.00	Excluded area salaries (see instructions)		6,564,688	16,250	6,580,938	323,640.00	20.33	2.00
3.00	Subtotal salaries (line 1 minus line 2)		22,774,433	-16,250	22,758,183	670,835.00	33.93	3.00
4.00	Subtotal other wages & related costs (see inst.)		9,698,804	0	9,698,804	193,844.00	50.03	4.00
5.00	Subtotal wage-related costs (see inst.)		4,265,142	0	4,265,142	0.00	18.74	5.00
6.00	Total (sum of lines 3 thru 5)		36,738,379	-16,250	36,722,129	864,679.00	42.47	6.00
7.00	Total overhead cost (see instructions)		5,188,190	-16,250	5,171,940	145,747.00	35.49	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part IV Date/Time Prepared: 9/11/2018 11:15 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	380,630	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	27,888	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	1,521,957	8.02
8.03	Health Insurance (Purchased)	69,041	8.03
9.00	Prescription Drug Plan	486,931	9.00
10.00	Dental, Hearing and Vision Plan	134,636	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	27,933	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)	107,695	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	345,467	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	2,053,164	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	41,204	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	56,359	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5,252,905	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part V Date/Time Prepared: 9/11/2018 11:15 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	908,396	5,252,905	1.00
2.00	Hospital	908,396	5,252,905	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF	0	0	9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-7 | Date/Time Prepared: 9/11/2018 11:15 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	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	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	192	0	192	12.00
13.00		RUB	207	0	207	13.00
14.00		RUA	589	0	589	14.00
15.00		RVC	473	0	473	15.00
16.00		RVB	659	0	659	16.00
17.00		RVA	901	0	901	17.00
18.00		RHC	80	0	80	18.00
19.00		RHB	88	0	88	19.00
20.00		RHA	102	0	102	20.00
21.00		RMC	2	0	2	21.00
22.00		RMB	21	0	21	22.00
23.00		RMA	23	0	23	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	5	0	5	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	12	0	12	32.00
33.00		HC2	18	0	18	33.00
34.00		HC1	7	0	7	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	35	0	35	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	7	0	7	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	6	0	6	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	23	0	23	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	17	0	17	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	9	0	9	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	23	0	23	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: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-7 | Date/Time Prepared: 9/11/2018 11:15 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	3	0	3	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	21	0	21	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	1	0	1	199.00
200.00	TOTAL		3,524	0	3,524	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).	19340		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	2,770,304	39.59	Y	202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	3,353	0.05	Y	204.00
205.00	Training	1,299	0.02	Y	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)	6,996,966			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-10 | Date/Time Prepared: 9/11/2018 11:15 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)	0.296580	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	17,571,076	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	49,316,811	6.00
7.00	Medicaid cost (line 1 times line 6)	14,626,380	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	3,686,145	0	3,686,145	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,093,237	0	1,093,237	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)	1,093,237	0	1,093,237	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)	5,294,505	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	251,197	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	386,457	27.01
28.00	Non-Medicare bad debt expense (see instructions)	4,908,048	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,590,889	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,684,126	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,684,126	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 9/11/2018 11:15 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	NEW CAP REL COSTS-BLDG & FIXT		2,175,798	2,175,798	-41,421	2,134,377	1.00
1.01	00101	NEW CAP RELATED IRC		379,540	379,540	0	379,540	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		1,968,981	1,968,981	0	1,968,981	2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC		0	0	0	0	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,851,447	2,851,447	0	2,851,447	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,159,015	23,961,847	25,120,862	0	25,120,862	5.00
7.00	00700	OPERATION OF PLANT	517,293	2,432,138	2,949,431	0	2,949,431	7.00
7.01	00701	OPERATION OF PLANT IRC	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	53,155	62,619	115,774	-35,393	80,381	8.00
9.00	00900	HOUSEKEEPING	0	755,343	755,343	-102,062	653,281	9.00
10.00	01000	DIETARY	0	665,520	665,520	-144,791	520,729	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	719,925	113,460	833,385	0	833,385	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	130,576	201,673	332,249	0	332,249	14.00
15.00	01500	PHARMACY	1,682,777	330,027	2,012,804	0	2,012,804	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
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,191,211	864,129	6,055,340	-350,630	5,704,710	30.00
31.00	03100	INTENSIVE CARE UNIT	884,401	305,765	1,190,166	0	1,190,166	31.00
43.00	04300	NURSERY	0	0	0	350,630	350,630	43.00
44.00	04400	SKILLED NURSING FACILITY	2,956,530	1,933,577	4,890,107	-38,104	4,852,003	44.00
45.00	04500	NURSING FACILITY	332,066	24,800	356,866	71,058	427,924	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,655,409	1,133,979	2,789,388	0	2,789,388	50.00
53.00	05300	ANESTHESIOLOGY	0	209,886	209,886	0	209,886	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,061,742	654,146	1,715,888	0	1,715,888	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	70,126	211,128	281,254	0	281,254	55.00
57.00	05700	CT SCAN	233,669	106,374	340,043	0	340,043	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	96,965	25,713	122,678	0	122,678	58.00
59.00	05900	CARDIAC CATHETERIZATION	494,036	486,748	980,784	0	980,784	59.00
60.00	06000	LABORATORY	2,244,473	4,286,554	6,531,027	0	6,531,027	60.00
65.00	06500	RESPIRATORY THERAPY	1,054,039	320,291	1,374,330	0	1,374,330	65.00
66.00	06600	PHYSICAL THERAPY	1,806,148	533,522	2,339,670	0	2,339,670	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,014,561	4,014,561	-2,513,968	1,500,593	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,513,968	2,513,968	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,850,053	4,850,053	0	4,850,053	73.00
76.00	03020	CARDIAC REHAB	385,731	112,927	498,658	0	498,658	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	18,878	1,754	20,632	0	20,632	90.00
90.01	09001	WOUND CENTER	166,625	248,916	415,541	0	415,541	90.01
91.00	09100	EMERGENCY	2,222,790	4,109,959	6,332,749	0	6,332,749	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,119,440	1,149,472	4,268,912	68,160	4,337,072	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,257,020	61,482,647	89,739,667	-222,553	89,517,114	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	49,493	49,493	18,708	68,201	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	26,243	603,760	630,003	8,033	638,036	192.00
192.01	19201	NONREIMBURSABLE	0	0	0	49,666	49,666	192.01
194.00	07950	CROSSTOWN SQUARE	130,409	816,835	947,244	1,355	948,599	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	134,613	134,613	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	10,178	10,178	194.03
194.04	07951	OUTREACH	0	885	885	0	885	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	28,413,672	62,953,620	91,367,292	0	91,367,292	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 9/11/2018 11:15 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-134,352	2,000,025		1.00
1.01	00101	NEW CAP RELATED IRC	-74,245	305,295		1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	1,968,981		2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC	0	0		2.01
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-883,568	1,967,879		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-10,904,909	14,215,953		5.00
7.00	00700	OPERATION OF PLANT	-29,270	2,920,161		7.00
7.01	00701	OPERATION OF PLANT IRC	0	0		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	-43,593	36,788		8.00
9.00	00900	HOUSEKEEPING	0	653,281		9.00
10.00	01000	DIETARY	-16,093	504,636		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	833,385		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	383,958	716,207		14.00
15.00	01500	PHARMACY	-14,224	1,998,580		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,007,075	1,007,075		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	157,570	5,862,280		30.00
31.00	03100	INTENSIVE CARE UNIT	-11,538	1,178,628		31.00
43.00	04300	NURSERY	0	350,630		43.00
44.00	04400	SKILLED NURSING FACILITY	-158,696	4,693,307		44.00
45.00	04500	NURSING FACILITY	0	427,924		45.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-35,000	2,754,388		50.00
53.00	05300	ANESTHESIOLOGY	-180,000	29,886		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-226,806	1,489,082		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	281,254		55.00
57.00	05700	CT SCAN	0	340,043		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	122,678		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	980,784		59.00
60.00	06000	LABORATORY	-760,816	5,770,211		60.00
65.00	06500	RESPIRATORY THERAPY	-54,371	1,319,959		65.00
66.00	06600	PHYSICAL THERAPY	-125,421	2,214,249		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-1,035	1,499,558		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,513,968		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,850,053		73.00
76.00	03020	CARDIAC REHAB	-130	498,528		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-40	20,592		90.00
90.01	09001	WOUND CENTER	-37,500	378,041		90.01
91.00	09100	EMERGENCY	-3,598,333	2,734,416		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-1,263,494	3,073,578		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-17,004,831	72,512,283		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-99,134	-30,933		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-433,208	204,828		192.00
192.01	19201	NONREIMBURSABLE	0	49,666		192.01
194.00	07950	CROSSTOWN SQUARE	-39,028	909,571		194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	134,613		194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	10,178		194.03
194.04	07951	OUTREACH	-6,568	-5,683		194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-17,582,769	73,784,523		200.00

COST CENTERS USED IN COST REPORT | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet Non-CMS W | Date/Time Prepared: 9/11/2018 11:15 am

	Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	NEW CAP REL COSTS-BLDG & FIXT	00100		1.00
1.01	NEW CAP RELATED IRC	00101		1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	00200		2.00
2.01	CAP REL COSTS-MVBLE EQUIP IRC	00201		2.01
3.00	OTHER CAPITAL RELATED COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
7.01	OPERATION OF PLANT IRC	00701		7.01
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
43.00	NURSERY	04300		43.00
44.00	SKILLED NURSING FACILITY	04400		44.00
45.00	NURSING FACILITY	04500		45.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	05000		50.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
55.00	RADIOLOGY-THERAPEUTIC	05500		55.00
57.00	CT SCAN	05700		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	05800		58.00
59.00	CARDIAC CATHETERIZATION	05900		59.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
76.00	CARDIAC REHAB	03020	ACUPUNCTURE	76.00
	OUTPATIENT SERVICE COST CENTERS			
90.00	CLINIC	09000		90.00
90.01	WOUND CENTER	09001		90.01
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	AMBULANCE SERVICES	09500		95.00
	SPECIAL PURPOSE COST CENTERS			
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)			118.00
	NONREIMBURSABLE COST CENTERS			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
192.01	NONREIMBURSABLE	19201		192.01
194.00	CROSSTOWN SQUARE	07950		194.00
194.02	NONALLOWABLE PHYSICIAN	07952		194.02
194.03	NONALLOWABLE GUEST MEALS	07953		194.03
194.04	OUTREACH	07951		194.04
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

RECLASSIFICATIONS | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 9/11/2018 11:15 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - POB DEPRECIATION				
1.00	NONREIMBURSABLE	192.01	0	41,421	1.00
	0		0	41,421	
	B - NURSING HOME OVERHEAD COSTS				
1.00	NURSING FACILITY	45.00	35,251	33,566	1.00
	0		35,251	33,566	
	C - NURSERY COSTS				
1.00	NURSERY	43.00	296,765	53,865	1.00
	0		296,765	53,865	
	D - CHARGEABLE SUPPLIES				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	2,513,968	1.00
	0		0	2,513,968	
	E - DIETARY COST AND EMPLOYEE MEALS				
1.00	NONALLOWABLE PHYSICIAN	194.02	0	134,613	1.00
2.00	NONALLOWABLE GUEST MEALS	194.03	0	10,178	2.00
	0		0	144,791	
	F - RECLASS HOUSEKEEPING COST				
1.00	AMBULANCE SERVICES	95.00	0	68,160	1.00
2.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	18,708	2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	6,949	3.00
4.00	NONREIMBURSABLE	192.01	0	8,245	4.00
	0		0	102,062	
	G - RECLASS LAUNDRY COST				
1.00	SKILLED NURSING FACILITY	44.00	14,101	16,612	1.00
2.00	NURSING FACILITY	45.00	1,029	1,212	2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	498	586	3.00
4.00	CROSSTOWN SQUARE	194.00	622	733	4.00
	0		16,250	19,143	
500.00	Grand Total: Increases		348,266	2,908,816	500.00

RECLASSIFICATIONS | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 9/11/2018 11:15 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - POB DEPRECIATION						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	41,421	9		1.00
	0		0	41,421			
	B - NURSING HOME OVERHEAD COSTS						
1.00	SKILLED NURSING FACILITY	44.00	35,251	33,566	0		1.00
	0		35,251	33,566			
	C - NURSERY COSTS						
1.00	ADULTS & PEDIATRICS	30.00	296,765	53,865	0		1.00
	0		296,765	53,865			
	D - CHARGEABLE SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,513,968	0		1.00
	0		0	2,513,968			
	E - DIETARY COST AND EMPLOYEE MEALS						
1.00	DIETARY	10.00	0	134,613	0		1.00
2.00	DIETARY	10.00	0	10,178	0		2.00
	0		0	144,791			
	F - RECLASS HOUSEKEEPING COST						
1.00	HOUSEKEEPING	9.00	0	102,062	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	0		0	102,062			
	G - RECLASS LAUNDRY COST						
1.00	LAUNDRY & LINEN SERVICE	8.00	16,250	19,143	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	0		16,250	19,143			
500.00	Grand Total: Decreases		348,266	2,908,816			500.00

RECLASSIFICATIONS | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 9/11/2018 11:15 am

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
	A - POB DEPRECIATION								
1.00	NONREIMBURSABLE	192.01	0	41,421	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	41,421	1.00
	0		0	41,421	0		0	41,421	
	B - NURSING HOME OVERHEAD COSTS								
1.00	NURSING FACILITY	45.00	35,251	33,566	SKILLED NURSING FACILITY	44.00	35,251	33,566	1.00
	0		35,251	33,566	0		35,251	33,566	
	C - NURSERY COSTS								
1.00	NURSERY	43.00	296,765	53,865	ADULTS & PEDIATRICS	30.00	296,765	53,865	1.00
	0		296,765	53,865	0		296,765	53,865	
	D - CHARGEABLE SUPPLIES								
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	2,513,968	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,513,968	1.00
	0		0	2,513,968	0		0	2,513,968	
	E - DIETARY COST AND EMPLOYEE MEALS								
1.00	NONALLOWABLE PHYSICIAN	194.02	0	134,613	DIETARY	10.00	0	134,613	1.00
2.00	NONALLOWABLE GUEST MEALS	194.03	0	10,178	DIETARY	10.00	0	10,178	2.00
	0		0	144,791	0		0	144,791	
	F - RECLASS HOUSEKEEPING COST								
1.00	AMBULANCE SERVICES	95.00	0	68,160	HOUSEKEEPING	9.00	0	102,062	1.00
2.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	18,708		0.00	0	0	2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	6,949		0.00	0	0	3.00
4.00	NONREIMBURSABLE	192.01	0	8,245		0.00	0	0	4.00
	0		0	102,062	0		0	102,062	
	G - RECLASS LAUNDRY COST								
1.00	SKILLED NURSING FACILITY	44.00	14,101	16,612	LAUNDRY & LINEN SERVICE	8.00	16,250	19,143	1.00
2.00	NURSING FACILITY	45.00	1,029	1,212		0.00	0	0	2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	498	586		0.00	0	0	3.00
4.00	CROSSTOWN SQUARE	194.00	622	733		0.00	0	0	4.00
	0		16,250	19,143	0		16,250	19,143	
500.00	Grand Total: Increases		348,266	2,908,816	Grand Total: Decreases		348,266	2,908,816	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part I | Date/Time Prepared: 9/11/2018 11:15 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,374,122	0	0	0	12,000	1.00
2.00	Land Improvements	5,043,535	260,504	0	260,504	0	2.00
3.00	Buildings and Fixtures	62,304,496	4,899,185	0	4,899,185	0	3.00
4.00	Building Improvements	2,090,594	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	50,096,252	917,834	0	917,834	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	121,908,999	6,077,523	0	6,077,523	12,000	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	121,908,999	6,077,523	0	6,077,523	12,000	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,362,122	0	1.00
2.00	Land Improvements	5,304,039	0	2.00
3.00	Buildings and Fixtures	67,203,681	0	3.00
4.00	Building Improvements	2,090,594	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	51,014,086	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	127,974,522	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	127,974,522	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part II Date/Time Prepared: 9/11/2018 11:15 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	NEW CAP REL COSTS-BLDG & FIXT	2,175,798	0	0	0	0	1.00
1.01	NEW CAP RELATED IRC	379,540	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,968,981	0	0	0	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP IRC	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	4,524,319	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	NEW CAP REL COSTS-BLDG & FIXT	0	2,175,798		1.00
1.01	NEW CAP RELATED IRC	0	379,540		1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,968,981		2.00
2.01	CAP REL COSTS-MVBLE EQUIP IRC	0	0		2.01
3.00	Total (sum of lines 1-2)	0	4,524,319		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part III Date/Time Prepared: 9/11/2018 11:15 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	74,598,313	0	74,598,313	0.593877	0	1.00
1.01	NEW CAP RELATED IRC	0	0	0	0.000000	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	51,014,086	0	51,014,086	0.406123	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP IRC	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	125,612,399	0	125,612,399	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	2,134,377	0	1.00
1.01	NEW CAP RELATED IRC	0	0	0	379,540	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,968,981	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP IRC	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	4,482,898	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	-134,352	0	0	0	2,000,025	1.00
1.01	NEW CAP RELATED IRC	-74,245	0	0	0	305,295	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,968,981	2.00
2.01	CAP REL COSTS-MVBLE EQUIP IRC	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	-208,597	0	0	0	4,274,301	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 9/11/2018 11:15 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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - NEW CAP RELATED IRC (chapter 2)		0	NEW CAP RELATED IRC	1.01	0	1.01
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - CAP REL COSTS-MVBLE EQUIP IRC (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP IRC	2.01	0	2.01
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	-3,973,509			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	-1,311,813			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP RELATED IRC		0	NEW CAP RELATED IRC	1.01	0	26.01
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - CAP REL COSTS-MVBLE EQUIP IRC		0	CAP REL COSTS-MVBLE EQUIP IRC	2.01	0	27.01
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 9/11/2018 11:15 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	
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	ADMINISTRATION - RENTAL INCOME -3RD	B	-37,587	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	ADMINISTRATION - DISCOUNTS EARNED	B	-7,856	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	ADMINISTRATION - INV INC - GENRAD IM	B	-32,479	ADMINISTRATIVE & GENERAL	5.00	0	35.00
35.03	ADMINISTRATOR - IRC - DISCOUNTS EARN	B	-1	ADMINISTRATIVE & GENERAL	5.00	0	35.03
35.05	ADMINISTRATOR - IRC - MISCELLANEOUS	B	-600	ADMINISTRATIVE & GENERAL	5.00	0	35.05
35.07	ADMINISTRATOR - CS - RENTAL INCOME -	B	-1,569	ADMINISTRATIVE & GENERAL	5.00	0	35.07
35.08	ADMINISTRATOR - CS - RENTAL INCOME -	B	-25,125	ADMINISTRATIVE & GENERAL	5.00	0	35.08
35.11	ADMINISTRATOR - CS - MISCELLANEOUS R	B	-1,530	ADMINISTRATIVE & GENERAL	5.00	0	35.11
35.13	INFORMATION TECHNOLOGY - MISCELLANEO	B	-4,006	ADMINISTRATIVE & GENERAL	5.00	0	35.13
35.14	MEDICAL STAFF - ILLINI - MISCELLANEO	B	-42,400	ADMINISTRATIVE & GENERAL	5.00	0	35.14
36.03	SWITCHBOARD - MISCELLANEOUS REVENUE	B	-484	ADMINISTRATIVE & GENERAL	5.00	0	36.03
36.07	SWITCHBOARD- CS - MISCELLANEOUS REVE	B	-8,632	ADMINISTRATIVE & GENERAL	5.00	0	36.07
36.08	PHYSICIAN SUPPORT SVCS - RENTAL INCO	B	-151,013	ADMINISTRATIVE & GENERAL	5.00	0	36.08
36.09	PHYSICIAN SUPPORT SVCS - RENTAL INCO	B	-1,320	ADMINISTRATIVE & GENERAL	5.00	0	36.09
36.10	GROUNDS - INTERCOMPANY REVENUE	B	-3,662	OPERATION OF PLANT	7.00	0	36.10
36.11	SECURITY - INTERCOMPANY REVENUE	B	-25,608	OPERATION OF PLANT	7.00	0	36.11
36.13	LAUNDRY - INTERCOMPANY REVENUE	B	-43,593	LAUNDRY & LINEN SERVICE	8.00	0	36.13
36.14	NUTRITIONAL SERVICES - VENDING SALES	B	-10,178	DIETARY	10.00	0	36.14
36.15	FOOD SERVICE - IRC - MISCELLANEOUS R	B	-3,751	DIETARY	10.00	0	36.15
36.18	FOOD SERVICE - CS - MISCELLANEOUS RE	B	-2,164	DIETARY	10.00	0	36.18
36.20	PHARMACY - INTERCOMPANY REVENUE	B	-14,224	PHARMACY	15.00	0	36.20
36.21	OB SERVICES - MISCELLANEOUS REVENUE	B	-155	ADULTS & PEDIATRICS	30.00	0	36.21
37.00	PEDIATRICS - MISCELLANEOUS REVENUE	B	-40	ADULTS & PEDIATRICS	30.00	0	37.00
37.06	BIRTH ASSOCIATES - MISCELLANEOUS REV	B	-2,578	ADULTS & PEDIATRICS	30.00	0	37.06
37.07	NURSING FLOOR - IRC MEDICARE - MISCE	B	-632	SKILLED NURSING FACILITY	44.00	0	37.07
37.09	RADIOLOGY - INTERCOMPANY REVENUE	B	-6,526	RADIOLOGY-DIAGNOSTIC	54.00	0	37.09
37.10	GIC-MLI-GENRAD IL - OUTREACH REVENUE	B	-220,280	RADIOLOGY-DIAGNOSTIC	54.00	0	37.10
37.11	CARDIAC CATH LAB - OUTREACH REVENUE	B	0	CARDIAC CATHETERIZATION	59.00	0	37.11
37.12	LABORATORY - INTERCOMPANY REVENUE	B	-32,698	LABORATORY	60.00	0	37.12
37.14	LABORATORY - MISCELLANEOUS REVENUE	B	-728,118	LABORATORY	60.00	0	37.14
38.00	CARDIOPULMONARY SERVICES - CLINIC RE	B	-13	RESPIRATORY THERAPY	65.00	0	38.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 9/11/2018 11:15 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	PHYSICAL THERAPY - MISCELLANEOUS REV	B	-1,333	PHYSICAL THERAPY	66.00	0	39.00
39.01	PHYSICAL THERAPY - RENTAL INCOME - R	B	-4,637	PHYSICAL THERAPY	66.00	0	39.01
39.02	P.T. CLINIC -MOLINE HEALTHPLEX - INT	B	-98,021	PHYSICAL THERAPY	66.00	0	39.02
39.03	P.T. CLINIC -MOLINE HEALTHPLEX - MIS	B	-15,840	PHYSICAL THERAPY	66.00	0	39.03
39.04	DISTRIBUTION - MISCELLANEOUS REVENUE	B	-1,035	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	39.04
40.00	CARDIAC REHAB - MISCELLANEOUS REVENU	B	-130	CARDIAC REHAB	76.00	0	40.00
41.00	DIABETES CARE CENTER - MISCELLANEOUS	B	-40	CLINIC	90.00	0	41.00
42.00	TRAUMA - MISCELLANEOUS REVENUE	B	-50,733	EMERGENCY	91.00	0	42.00
42.01	AMBULANCE - CPE REVENUE	B	-28,805	AMBULANCE SERVICES	95.00	0	42.01
43.00	AMBULANCE - MISCELLANEOUS REVENUE	B	-620,334	AMBULANCE SERVICES	95.00	0	43.00
43.02	AMBULANCE OUTREACH - MISCELLANEOUS R	B	-614,332	AMBULANCE SERVICES	95.00	0	43.02
43.03	OUTSIDE SERVICE SPA - IRC - MISCELLA	B	-22,015	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	43.03
43.04	OUTSIDE SERVICE SPA - CS - MISCELLAN	B	-10,862	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	43.04
43.06	AUXILIARY - GIFT SHOP - MISCELLANEOU	B	-65,917	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	43.06
43.07	AUXILIARY - MISCELLANEOUS REVENUE	B	-340	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	43.07
43.09	PHYSICIAN OFFICE - RENTAL INCOME -3R	B	-66,401	PHYSICIANS' PRIVATE OFFICES	192.00	0	43.09
43.10	PHYSICIAN OFFICE - RENTAL INCOME - R	B	-128,760	PHYSICIANS' PRIVATE OFFICES	192.00	0	43.10
43.11	2526 41ST ST. - MOLINE - RENTAL INCO	B	-25,795	PHYSICIANS' PRIVATE OFFICES	192.00	0	43.11
43.12	2526 41ST ST. - MOLINE - RENTAL INCO	B	-110,942	PHYSICIANS' PRIVATE OFFICES	192.00	0	43.12
43.13	GENESIS HEALTHPLEX-MOLINE - RENTAL I	B	-101,310	PHYSICIANS' PRIVATE OFFICES	192.00	0	43.13
43.14	NURSING FLOOR - CS - MISCELLANEOUS R	B	-2,330	CROSSTOWN SQUARE	194.00	0	43.14
43.15	ENVIRONMENTAL SVC - OUTREACH - OTHER	B	-6,568	OUTREACH	194.04	0	43.15
44.00	INTEREST - INTEREST EXPENSE - 2010 B	A	-159,909	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	44.00
44.01	INTEREST - INTEREST EXP CAP INT OFF	A	25,557	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	44.01
44.02	INTEREST- IRC - INTEREST EXPENSE - R	A	-74,245	NEW CAP RELATED IRC	1.01	11	44.02
44.03	INTEREST - CS - INTEREST EXPENSE - R	A	-27,460	CROSSTOWN SQUARE	194.00	0	44.03
44.04	ADMINISTRATION - MISCELLANEOUS REVEN	A	-12,009	ADMINISTRATIVE & GENERAL	5.00	0	44.04
44.05	NURSING FLOOR - IRC MEDICARE - CONTR	A	-47,327	SKILLED NURSING FACILITY	44.00	0	44.05
44.06	ENVIRONMENTAL SVCS - IRC - CONTRACT	A	-42,588	SKILLED NURSING FACILITY	44.00	0	44.06
45.00	ENVIRONMENTAL SVC - CS - CONTRACT FE	A	-1,005	CROSSTOWN SQUARE	194.00	0	45.00
45.01	SECURITY - IRC - CONTRACT FEES- ILLI	A	-17,400	SKILLED NURSING FACILITY	44.00	0	45.01
45.02	SECURITY - CS - CONTRACT FEES- ILLIN	A	-8,208	CROSSTOWN SQUARE	194.00	0	45.02
45.03	ADMINISTRATION - PHYSICIAN PRACTICE	A	-4,151,033	ADMINISTRATIVE & GENERAL	5.00	0	45.03
45.04	PHYSICIAN SUPPORT SVCS	A	-180,714	ADMINISTRATIVE & GENERAL	5.00	0	45.04
45.05	MEDICAL STAFF - ILLINI - DONATIONS	A	-15,600	ADMINISTRATIVE & GENERAL	5.00	0	45.05
45.06	ALCOHOL	A	-17	ADMINISTRATIVE & GENERAL	5.00	0	45.06
45.07	ALCOHOL - IRC	A	-354	SKILLED NURSING FACILITY	44.00	0	45.07
45.08	ADVERTISING & PROMOTIONS	A	-25,642	ADMINISTRATIVE & GENERAL	5.00	0	45.08
45.09	ADVERTISING & PROMOTIONS	A	-25	SKILLED NURSING FACILITY	44.00	0	45.09

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 9/11/2018 11:15 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	
45.10	ADVERTISING & PROMOTIONS	A	-5,590	PHYSICAL THERAPY	66.00	0	45.10
45.11	ADVERTISING & PROMOTIONS	A	-25	CROSSTOWN SQUARE	194.00	0	45.11
45.12	ADMINISTRATION - PROVIDER TAX ASSESS	A	-3,071,939	ADMINISTRATIVE & GENERAL	5.00	0	45.12
45.13	NURSING ADMIN - IRC - PROVIDER TAX A	A	-50,370	SKILLED NURSING FACILITY	44.00	0	45.13
45.14	ADMINISTRATOR - IRC - PROVIDER TAX A	A	-134,105	ADMINISTRATIVE & GENERAL	5.00	0	45.14
45.15	SELF INSURANCE	A	-883,568	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.15
45.16	LOBBYING	A	-28,569	ADMINISTRATIVE & GENERAL	5.00	0	45.16
45.17	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.17
45.18	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.18
45.19	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.19
45.20	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.20
45.21	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.21
45.22	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.22
45.23	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.23
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-17,582,769				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: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-1 | Date/Time Prepared: 9/11/2018 11:15 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	5.00	ADMINISTRATIVE & GENERAL	GHS HOME OFFICE COSTS	11,566,947	14,269,793	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	14.00	CENTRAL SERVICES & SUPPLY	GHS HOME OFFICE COSTS	383,958	0	4.00
4.01	16.00	MEDICAL RECORDS & LIBRARY	GHS HOME OFFICE COSTS	1,007,075	0	4.01
4.02	0.00			0	0	4.02
4.03	0.00			0	0	4.03
4.04	0.00		GHS HOME OFFICE COSTS	0	0	4.04
5.00	0		0	12,957,980	14,269,793	5.00

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

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

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

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

6.00	C		0.00	GENESIS HEALTH SYSTEM	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: 14-0275	Period: From 07/01/2017 To 06/30/2018	Worksheet A-8-1 Date/Time Prepared: 9/11/2018 11:15 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	-2,702,846	0		1.00
2.00	0	9		2.00
3.00	0	0		3.00
4.00	383,958	0		4.00
4.01	1,007,075	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
5.00	-1,311,813			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	HOME OFFICE		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: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-2 | Date/Time Prepared: 9/11/2018 11:15 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	5.00	ADMINISTRATIVE & GENERAL	284,568	267,833	16,735	211,500	165	1.00
2.00	30.00	ADULTS & PEDIATRICS	-160,343	-160,343	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	11,538	11,538	0	0	0	3.00
4.00	50.00	OPERATING ROOM	35,000	35,000	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	180,000	180,000	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	260,300	0	6.00
7.00	65.00	RESPIRATORY THERAPY	54,358	54,358	0	211,500	0	7.00
8.00	90.01	WOUND CENTER	37,500	37,500	0	0	0	8.00
9.00	91.00	EMERGENCY	3,555,735	3,547,585	8,150	211,500	80	9.00
10.00	95.00	AMBULANCE SERVICES	11,310	0	11,310	211,500	111	10.00
200.00			4,009,666	3,973,471	36,195		356	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	16,778	839	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	7.00
8.00	90.01	WOUND CENTER	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	8,135	407	0	0	0	9.00
10.00	95.00	AMBULANCE SERVICES	11,287	564	0	0	0	10.00
200.00			36,200	1,810	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	16,778	0	267,833		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	-160,343		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	11,538		3.00
4.00	50.00	OPERATING ROOM	0	0	0	35,000		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	180,000		5.00
6.00	60.00	LABORATORY	0	0	0	0		6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	54,358		7.00
8.00	90.01	WOUND CENTER	0	0	0	37,500		8.00
9.00	91.00	EMERGENCY	0	8,135	15	3,547,600		9.00
10.00	95.00	AMBULANCE SERVICES	0	11,287	23	23		10.00
200.00			0	36,200	38	3,973,509		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 9/11/2018 11:15 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	NEW CAP RELATED IRC	NEW MVBLE EQUIP	MVBLE EQUIP IRC	
			0	1.00	1.01	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,000,025	2,000,025				1.00
1.01	00101	NEW CAP RELATED IRC	305,295	0	305,295			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,968,981			1,968,981		2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC	0			0	0	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,967,879	4,865	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,215,953	466,970	0	184,967	0	5.00
7.00	00700	OPERATION OF PLANT	2,920,161	188,777	0	48,464	0	7.00
7.01	00701	OPERATION OF PLANT IRC	0	0	13,063	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	36,788	20,799	1,054	0	0	8.00
9.00	00900	HOUSEKEEPING	653,281	9,487	2,306	5,633	0	9.00
10.00	01000	DIETARY	504,636	45,880	0	11,554	0	10.00
11.00	01100	CAFETERIA	0	25,473	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	833,385	6,776	0	30,812	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	716,207	58,104	0	19,159	0	14.00
15.00	01500	PHARMACY	1,998,580	40,311	0	62,694	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,007,075	23,909	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	9,591	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,862,280	373,697	0	207,276	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,178,628	32,492	0	40,681	0	31.00
43.00	04300	NURSERY	350,630	18,844	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	4,693,307	0	174,307	12,984	0	44.00
45.00	04500	NURSING FACILITY	427,924	0	83,977	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,754,388	139,934	0	223,869	0	50.00
53.00	05300	ANESTHESIOLOGY	29,886	0	0	33,289	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,489,082	76,956	0	230,464	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	281,254	0	0	0	0	55.00
57.00	05700	CT SCAN	340,043	0	0	148,740	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	122,678	1,581	0	6,760	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	980,784	20,920	0	17,768	0	59.00
60.00	06000	LABORATORY	5,770,211	130,178	0	96,439	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,319,959	24,430	0	69,950	0	65.00
66.00	06600	PHYSICAL THERAPY	2,214,249	29,417	23,523	21,791	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,499,558	0	0	70,121	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,513,968	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,850,053	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	498,528	75,584	0	667	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	20,592	0	0	0	0	90.00
90.01	09001	WOUND CENTER	378,041	16,446	0	7,110	0	90.01
91.00	09100	EMERGENCY	2,734,416	76,765	0	92,452	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,073,578	61,692	0	322,448	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	72,512,283	1,979,878	298,230	1,966,092	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-30,933	13,857	2,062	169	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	204,828	6,290	0	1,665	0	192.00
192.01	19201	NONREIMBURSABLE	49,666	0	5,003	0	0	192.01
194.00	07950	CROSSTOWN SQUARE	909,571	0	0	1,055	0	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	134,613	0	0	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	10,178	0	0	0	0	194.03
194.04	07951	OUTREACH	-5,683	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	73,784,523	2,000,025	305,295	1,968,981	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 9/11/2018 11:15 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT IRC	
			4.00	4A	5.00	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,972,744					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	80,469	14,948,359	14,948,359			5.00
7.00	00700	OPERATION OF PLANT	35,915	3,193,317	811,035	4,004,352		7.00
7.01	00701	OPERATION OF PLANT IRC	0	13,063	3,318	0	16,381	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	2,562	61,203	15,544	62,180	59	8.00
9.00	00900	HOUSEKEEPING	0	670,707	170,345	28,363	129	9.00
10.00	01000	DIETARY	0	562,070	142,754	137,165	0	10.00
11.00	01100	CAFETERIA	0	25,473	6,470	76,154	0	11.00
13.00	01300	NURSING ADMINISTRATION	49,984	920,957	233,904	20,259	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,066	802,536	203,827	173,709	0	14.00
15.00	01500	PHARMACY	116,834	2,218,419	563,432	120,516	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,030,984	261,848	71,478	0	16.00
17.00	01700	SOCIAL SERVICE	0	9,591	2,436	28,674	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	339,827	6,783,080	1,722,755	1,117,214	0	30.00
31.00	03100	INTENSIVE CARE UNIT	61,403	1,313,204	333,526	97,140	0	31.00
43.00	04300	NURSERY	20,604	390,078	99,072	56,336	0	43.00
44.00	04400	SKILLED NURSING FACILITY	203,800	5,084,398	1,291,330	0	9,771	44.00
45.00	04500	NURSING FACILITY	25,574	537,475	136,507	0	4,707	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	114,933	3,233,124	821,146	418,352	0	50.00
53.00	05300	ANESTHESIOLOGY	0	63,175	16,045	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	73,716	1,870,218	474,996	230,071	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,869	286,123	72,669	0	0	55.00
57.00	05700	CT SCAN	16,223	505,006	128,261	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,732	137,751	34,986	4,727	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	34,300	1,053,772	267,636	62,544	0	59.00
60.00	06000	LABORATORY	155,832	6,152,660	1,562,646	389,184	0	60.00
65.00	06500	RESPIRATORY THERAPY	73,181	1,487,520	377,799	73,037	0	65.00
66.00	06600	PHYSICAL THERAPY	125,399	2,414,379	613,202	87,946	1,319	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,569,679	398,666	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,513,968	638,495	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,850,053	1,231,812	0	0	73.00
76.00	03020	CARDIAC REHAB	26,781	601,560	152,784	225,968	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,311	21,903	5,563	0	0	90.00
90.01	09001	WOUND CENTER	11,569	413,166	104,935	49,167	0	90.01
91.00	09100	EMERGENCY	154,326	3,057,959	776,657	229,500	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	216,580	3,674,298	933,195	184,436	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,961,790	72,471,228	14,609,596	3,944,120	15,985	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	-14,845	0	41,427	116	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,857	214,640	54,514	18,805	0	192.00
192.01	19201	NONREIMBURSABLE	0	54,669	13,885	0	280	192.01
194.00	07950	CROSSTOWN SQUARE	9,097	919,723	233,590	0	0	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	134,613	34,189	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	10,178	2,585	0	0	194.03
194.04	07951	OUTREACH	0	-5,683	0	0	0	194.04
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,972,744	73,784,523	14,948,359	4,004,352	16,381	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 9/11/2018 11:15 am

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT IRC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE	138,986					8.00
9.00	00900	HOUSEKEEPING	0	869,544				9.00
10.00	01000	DIETARY	0	32,668	874,657			10.00
11.00	01100	CAFETERIA	0	18,137	697,956	824,190		11.00
13.00	01300	NURSING ADMINISTRATION	0	4,825	0	16,852	1,196,797	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	684	41,371	0	7,411	843	14.00
15.00	01500	PHARMACY	0	9,792	0	32,992	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	17,024	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	6,829	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,815	266,079	161,007	151,699	577,623	30.00
31.00	03100	INTENSIVE CARE UNIT	3,836	23,135	15,694	21,989	102,941	31.00
43.00	04300	NURSERY	2,433	13,417	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	40,305	0	0	114,491	0	44.00
45.00	04500	NURSING FACILITY	2,941	0	0	13,311	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	22,505	99,636	0	44,516	193,907	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,403	54,795	0	31,395	2,462	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	1,701	4	55.00
57.00	05700	CT SCAN	3,980	0	0	6,439	53	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	742	1,126	0	2,291	12	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,653	14,896	0	7,063	19,020	59.00
60.00	06000	LABORATORY	16	54,745	0	80,128	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,035	17,395	0	32,298	25	65.00
66.00	06600	PHYSICAL THERAPY	1,302	24,985	0	49,254	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	58	36,546	0	10,656	19,366	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	486	1,065	90.00
90.01	09001	WOUND CENTER	0	11,710	0	4,582	19,209	90.01
91.00	09100	EMERGENCY	20,391	54,658	0	53,349	259,971	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	43,926	0	133,356	296	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	137,099	847,695	874,657	816,259	1,196,797	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,056	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,887	4,479	0	1,319	0	192.00
192.01	19201	NONREIMBURSABLE	0	5,314	0	0	0	192.01
194.00	07950	CROSSTOWN SQUARE	0	0	0	6,612	0	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	0	194.03
194.04	07951	OUTREACH	0	0	0	0	0	194.04
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)	138,986	869,544	874,657	824,190	1,196,797	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 9/11/2018 11:15 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			14.00	15.00	16.00	17.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT IRC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,230,381					14.00
15.00	01500	PHARMACY	11,583	2,956,734				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,381,334			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	47,530		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	69,622	0	90,497	39,952	11,006,343	30.00
31.00	03100	INTENSIVE CARE UNIT	14,367	0	17,708	3,940	1,947,480	31.00
43.00	04300	NURSERY	0	0	0	3,638	564,974	43.00
44.00	04400	SKILLED NURSING FACILITY	40,324	0	43,307	0	6,623,926	44.00
45.00	04500	NURSING FACILITY	0	0	4,979	0	699,920	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	124,340	0	110,604	0	5,068,130	50.00
53.00	05300	ANESTHESIOLOGY	5,677	0	15,541	0	100,438	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,827	0	70,883	0	2,753,050	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	38,699	0	11,956	0	411,152	55.00
57.00	05700	CT SCAN	13,566	0	144,594	0	801,899	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	446	0	29,533	0	211,614	58.00
59.00	05900	CARDIAC CATHETERIZATION	17,557	0	63,449	0	1,507,590	59.00
60.00	06000	LABORATORY	6,849	0	222,258	0	8,468,486	60.00
65.00	06500	RESPIRATORY THERAPY	18,843	0	73,976	0	2,081,928	65.00
66.00	06600	PHYSICAL THERAPY	2,543	0	46,110	0	3,241,040	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	269,245	0	81,715	0	2,319,305	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	509,798	0	0	0	3,662,261	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,956,734	134,574	0	9,173,173	73.00
76.00	03020	CARDIAC REHAB	1,237	0	5,924	0	1,054,099	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	298	0	29,315	90.00
90.01	09001	WOUND CENTER	7,669	0	20,080	0	630,518	90.01
91.00	09100	EMERGENCY	52,772	0	193,348	0	4,698,605	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	15,378	0	0	0	4,984,885	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,230,342	2,956,734	1,381,334	47,530	72,040,131	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	38,754	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	295,644	192.00
192.01	19201	NONREIMBURSABLE	0	0	0	0	74,148	192.01
194.00	07950	CROSSTOWN SQUARE	39	0	0	0	1,159,964	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	0	168,802	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	12,763	194.03
194.04	07951	OUTREACH	0	0	0	0	-5,683	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,230,381	2,956,734	1,381,334	47,530	73,784,523	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 9/11/2018 11:15 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP RELATED IRC				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT IRC				7.01
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	11,006,343		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,947,480		31.00
43.00	04300	NURSERY	0	564,974		43.00
44.00	04400	SKILLED NURSING FACILITY	0	6,623,926		44.00
45.00	04500	NURSING FACILITY	0	699,920		45.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	5,068,130		50.00
53.00	05300	ANESTHESIOLOGY	0	100,438		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,753,050		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	411,152		55.00
57.00	05700	CT SCAN	0	801,899		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	211,614		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,507,590		59.00
60.00	06000	LABORATORY	0	8,468,486		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,081,928		65.00
66.00	06600	PHYSICAL THERAPY	0	3,241,040		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,319,305		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	3,662,261		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,173,173		73.00
76.00	03020	CARDIAC REHAB	0	1,054,099		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	29,315		90.00
90.01	09001	WOUND CENTER	0	630,518		90.01
91.00	09100	EMERGENCY	0	4,698,605		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	4,984,885		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	72,040,131		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	38,754		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	295,644		192.00
192.01	19201	NONREIMBURSABLE	0	74,148		192.01
194.00	07950	CROSSTOWN SQUARE	0	1,159,964		194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	168,802		194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	12,763		194.03
194.04	07951	OUTREACH	0	-5,683		194.04
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	73,784,523		202.00

COST ALLOCATION STATISTICS | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet Non-CMS W | Date/Time Prepared: 9/11/2018 11:15 am

	Cost Center Description	Statistics Code	Statistics Description	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE FEET	1.00
1.01	NEW CAP RELATED IRC	4	SQUARE FEET IRC	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	5	DOLLAR VALUE	2.00
2.01	CAP REL COSTS-MVBLE EQUIP IRC	2	DOLLAR VALUE	2.01
4.00	EMPLOYEE BENEFITS DEPARTMENT	6	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-7	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	8	SQUARE FEET	7.00
7.01	OPERATION OF PLANT IRC	9	SQUARE FEET IRC	7.01
8.00	LAUNDRY & LINEN SERVICE	10	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	11	SQUARE FEET	9.00
10.00	DIETARY	12	MEALS SERVED	10.00
11.00	CAFETERIA	13	FTE'S	11.00
13.00	NURSING ADMINISTRATION	14	DIRECT NRSING HRS	13.00
14.00	CENTRAL SERVICES & SUPPLY	15	COSTED REQUIS.	14.00
15.00	PHARMACY	16	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	17	GROSS REVENUE	16.00
17.00	SOCIAL SERVICE	18	TIME SPENT	17.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 9/11/2018 11:15 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW CAP RELATED IRC	NEW MVBLE EQUIP	MVBLE EQUIP IRC	
			0	1.00	1.01	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,865	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	284,494	466,970	0	184,967	0	5.00
7.00	00700	OPERATION OF PLANT	236,167	188,777	0	48,464	0	7.00
7.01	00701	OPERATION OF PLANT IRC	0	0	13,063	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	20,799	1,054	0	0	8.00
9.00	00900	HOUSEKEEPING	2,418	9,487	2,306	5,633	0	9.00
10.00	01000	DIETARY	23,199	45,880	0	11,554	0	10.00
11.00	01100	CAFETERIA	0	25,473	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,943	6,776	0	30,812	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	86,912	58,104	0	19,159	0	14.00
15.00	01500	PHARMACY	90,706	40,311	0	62,694	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	23,909	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	9,591	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	48,832	373,697	0	207,276	0	30.00
31.00	03100	INTENSIVE CARE UNIT	6,562	32,492	0	40,681	0	31.00
43.00	04300	NURSERY	0	18,844	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	96,027	0	174,307	12,984	0	44.00
45.00	04500	NURSING FACILITY	0	0	83,977	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	83,498	139,934	0	223,869	0	50.00
53.00	05300	ANESTHESIOLOGY	210	0	0	33,289	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,477	76,956	0	230,464	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	9,664	0	0	148,740	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	13,273	1,581	0	6,760	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,366	20,920	0	17,768	0	59.00
60.00	06000	LABORATORY	218,928	130,178	0	96,439	0	60.00
65.00	06500	RESPIRATORY THERAPY	61,169	24,430	0	69,950	0	65.00
66.00	06600	PHYSICAL THERAPY	296,160	29,417	23,523	21,791	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	70,121	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	71,649	75,584	0	667	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	671	0	0	0	0	90.00
90.01	09001	WOUND CENTER	44,993	16,446	0	7,110	0	90.01
91.00	09100	EMERGENCY	11,705	76,765	0	92,452	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	304,150	61,692	0	322,448	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,010,173	1,979,878	298,230	1,966,092	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,857	2,062	169	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	348,051	6,290	0	1,665	0	192.00
192.01	19201	NONREIMBURSABLE	0	0	5,003	0	0	192.01
194.00	07950	CROSSTOWN SQUARE	6,894	0	0	1,055	0	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	0	194.03
194.04	07951	OUTREACH	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,365,118	2,000,025	305,295	1,968,981	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 9/11/2018 11:15 am

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT IRC	
			2A	4.00	5.00	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,865	4,865				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	936,431	198	936,629			5.00
7.00	00700	OPERATION OF PLANT	473,408	88	50,818	524,314		7.00
7.01	00701	OPERATION OF PLANT IRC	13,063	0	208	0	13,271	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	21,853	6	974	8,142	48	8.00
9.00	00900	HOUSEKEEPING	19,844	0	10,674	3,714	105	9.00
10.00	01000	DIETARY	80,633	0	8,945	17,960	0	10.00
11.00	01100	CAFETERIA	25,473	0	405	9,971	0	11.00
13.00	01300	NURSING ADMINISTRATION	41,531	123	14,656	2,653	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	164,175	22	12,772	22,745	0	14.00
15.00	01500	PHARMACY	193,711	288	35,304	15,780	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	23,909	0	16,407	9,359	0	16.00
17.00	01700	SOCIAL SERVICE	9,591	0	153	3,755	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	629,805	845	107,931	146,284	0	30.00
31.00	03100	INTENSIVE CARE UNIT	79,735	151	20,898	12,719	0	31.00
43.00	04300	NURSERY	18,844	51	6,208	7,376	0	43.00
44.00	04400	SKILLED NURSING FACILITY	283,318	502	80,913	0	7,915	44.00
45.00	04500	NURSING FACILITY	83,977	63	8,553	0	3,814	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	447,301	283	51,452	54,777	0	50.00
53.00	05300	ANESTHESIOLOGY	33,499	0	1,005	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	319,897	182	29,763	30,125	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	12	4,553	0	0	55.00
57.00	05700	CT SCAN	158,404	40	8,037	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	21,614	17	2,192	619	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	41,054	84	16,770	8,189	0	59.00
60.00	06000	LABORATORY	445,545	384	97,913	50,958	0	60.00
65.00	06500	RESPIRATORY THERAPY	155,549	180	23,672	9,563	0	65.00
66.00	06600	PHYSICAL THERAPY	370,891	309	38,422	11,515	1,068	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	70,121	0	24,980	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	40,007	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	77,184	0	0	73.00
76.00	03020	CARDIAC REHAB	147,900	66	9,573	29,587	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	671	3	349	0	0	90.00
90.01	09001	WOUND CENTER	68,549	28	6,575	6,438	0	90.01
91.00	09100	EMERGENCY	180,922	380	48,664	30,050	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	688,290	533	58,473	24,149	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,254,373	4,838	915,403	516,428	12,950	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	16,088	0	0	5,424	94	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	356,006	5	3,416	2,462	0	192.00
192.01	19201	NONREIMBURSABLE	5,003	0	870	0	227	192.01
194.00	07950	CROSSTOWN SQUARE	7,949	22	14,636	0	0	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	2,142	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	162	0	0	194.03
194.04	07951	OUTREACH	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,639,419	4,865	936,629	524,314	13,271	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 9/11/2018 11:15 am

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT IRC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE	31,023					8.00
9.00	00900	HOUSEKEEPING	0	34,337				9.00
10.00	01000	DIETARY	0	1,290	108,828			10.00
11.00	01100	CAFETERIA	0	716	86,842	123,407		11.00
13.00	01300	NURSING ADMINISTRATION	0	191	0	2,523	61,677	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	153	1,634	0	1,110	43	14.00
15.00	01500	PHARMACY	0	387	0	4,940	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	672	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	270	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,985	10,506	20,033	22,713	29,768	30.00
31.00	03100	INTENSIVE CARE UNIT	856	914	1,953	3,292	5,305	31.00
43.00	04300	NURSERY	543	530	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	8,996	0	0	17,143	0	44.00
45.00	04500	NURSING FACILITY	656	0	0	1,993	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,023	3,934	0	6,665	9,993	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,876	2,164	0	4,701	127	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	255	0	55.00
57.00	05700	CT SCAN	888	0	0	964	3	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	166	44	0	343	1	58.00
59.00	05900	CARDIAC CATHETERIZATION	369	588	0	1,058	980	59.00
60.00	06000	LABORATORY	4	2,162	0	11,998	0	60.00
65.00	06500	RESPIRATORY THERAPY	231	687	0	4,836	1	65.00
66.00	06600	PHYSICAL THERAPY	291	987	0	7,375	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	13	1,443	0	1,596	998	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	73	55	90.00
90.01	09001	WOUND CENTER	0	462	0	686	990	90.01
91.00	09100	EMERGENCY	4,552	2,158	0	7,988	13,398	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,735	0	19,968	15	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,602	33,474	108,828	122,220	61,677	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	476	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	421	177	0	197	0	192.00
192.01	19201	NONREIMBURSABLE	0	210	0	0	0	192.01
194.00	07950	CROSSTOWN SQUARE	0	0	0	990	0	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	0	194.03
194.04	07951	OUTREACH	0	0	0	0	0	194.04
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)	31,023	34,337	108,828	123,407	61,677	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 9/11/2018 11:15 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			14.00	15.00	16.00	17.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT IRC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	202,654					14.00
15.00	01500	PHARMACY	1,908	252,318				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	50,347			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	13,769		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,468	0	3,292	11,574	1,000,204	30.00
31.00	03100	INTENSIVE CARE UNIT	2,366	0	644	1,141	129,974	31.00
43.00	04300	NURSERY	0	0	0	1,054	34,606	43.00
44.00	04400	SKILLED NURSING FACILITY	6,642	0	1,575	0	407,004	44.00
45.00	04500	NURSING FACILITY	0	0	181	0	99,237	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,480	0	4,023	0	603,931	50.00
53.00	05300	ANESTHESIOLOGY	935	0	565	0	36,004	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,619	0	2,578	0	393,032	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,374	0	435	0	11,629	55.00
57.00	05700	CT SCAN	2,234	0	5,260	0	175,830	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	73	0	1,074	0	26,143	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,892	0	2,308	0	74,292	59.00
60.00	06000	LABORATORY	1,128	0	8,187	0	618,279	60.00
65.00	06500	RESPIRATORY THERAPY	3,104	0	2,691	0	200,514	65.00
66.00	06600	PHYSICAL THERAPY	419	0	1,677	0	432,954	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	44,348	0	2,973	0	142,422	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	83,966	0	0	0	123,973	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	252,318	4,895	0	334,397	73.00
76.00	03020	CARDIAC REHAB	204	0	215	0	191,595	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	11	0	1,162	90.00
90.01	09001	WOUND CENTER	1,263	0	730	0	85,721	90.01
91.00	09100	EMERGENCY	8,692	0	7,033	0	303,837	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,533	0	0	0	795,696	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	202,648	252,318	50,347	13,769	6,222,436	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	22,082	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	362,684	192.00
192.01	19201	NONREIMBURSABLE	0	0	0	0	6,310	192.01
194.00	07950	CROSSTOWN SQUARE	6	0	0	0	23,603	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	0	2,142	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	162	194.03
194.04	07951	OUTREACH	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	202,654	252,318	50,347	13,769	6,639,419	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 9/11/2018 11:15 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP RELATED IRC				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT IRC				7.01
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,000,204		30.00
31.00	03100	INTENSIVE CARE UNIT	0	129,974		31.00
43.00	04300	NURSERY	0	34,606		43.00
44.00	04400	SKILLED NURSING FACILITY	0	407,004		44.00
45.00	04500	NURSING FACILITY	0	99,237		45.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	603,931		50.00
53.00	05300	ANESTHESIOLOGY	0	36,004		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	393,032		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	11,629		55.00
57.00	05700	CT SCAN	0	175,830		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	26,143		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	74,292		59.00
60.00	06000	LABORATORY	0	618,279		60.00
65.00	06500	RESPIRATORY THERAPY	0	200,514		65.00
66.00	06600	PHYSICAL THERAPY	0	432,954		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	142,422		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	123,973		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	334,397		73.00
76.00	03020	CARDIAC REHAB	0	191,595		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	1,162		90.00
90.01	09001	WOUND CENTER	0	85,721		90.01
91.00	09100	EMERGENCY	0	303,837		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	795,696		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	6,222,436		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22,082		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	362,684		192.00
192.01	19201	NONREIMBURSABLE	0	6,310		192.01
194.00	07950	CROSSTOWN SQUARE	0	23,603		194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	2,142		194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	162		194.03
194.04	07951	OUTREACH	0	0		194.04
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	6,639,419		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 9/11/2018 11:15 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW CAP RELATED IRC (SQUARE FEET IRC)	NEW MVBLE EQUIP (DOLLAR VALUE)	MVBLE EQUIP IRC (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			1.00	1.01	2.00	2.01	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	230,211					1.00
1.01	00101	NEW CAP RELATED IRC	0	52,420				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			1,911,104			2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC			0	0		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	560	0	0	0	28,413,671	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	53,750	0	179,530	0	1,159,015	5.00
7.00	00700	OPERATION OF PLANT	21,729	0	47,039	0	517,293	7.00
7.01	00701	OPERATION OF PLANT IRC	0	2,243	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	2,394	181	0	0	36,905	8.00
9.00	00900	HOUSEKEEPING	1,092	396	5,467	0	0	9.00
10.00	01000	DIETARY	5,281	0	11,214	0	0	10.00
11.00	01100	CAFETERIA	2,932	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	780	0	29,906	0	719,925	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,688	0	18,596	0	130,576	14.00
15.00	01500	PHARMACY	4,640	0	60,851	0	1,682,777	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,752	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,104	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	43,014	0	201,183	0	4,894,445	30.00
31.00	03100	INTENSIVE CARE UNIT	3,740	0	39,485	0	884,401	31.00
43.00	04300	NURSERY	2,169	0	0	0	296,765	43.00
44.00	04400	SKILLED NURSING FACILITY	0	29,929	12,602	0	2,935,380	44.00
45.00	04500	NURSING FACILITY	0	14,419	0	0	368,346	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,107	0	217,288	0	1,655,409	50.00
53.00	05300	ANESTHESIOLOGY	0	0	32,310	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,858	0	223,690	0	1,061,742	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	70,126	55.00
57.00	05700	CT SCAN	0	0	144,368	0	233,669	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	182	0	6,561	0	96,965	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,408	0	17,246	0	494,036	59.00
60.00	06000	LABORATORY	14,984	0	93,604	0	2,244,473	60.00
65.00	06500	RESPIRATORY THERAPY	2,812	0	67,894	0	1,054,039	65.00
66.00	06600	PHYSICAL THERAPY	3,386	4,039	21,150	0	1,806,148	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	68,060	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	8,700	0	647	0	385,731	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	18,878	90.00
90.01	09001	WOUND CENTER	1,893	0	6,901	0	166,625	90.01
91.00	09100	EMERGENCY	8,836	0	89,734	0	2,222,790	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	7,101	0	312,974	0	3,119,440	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	227,892	51,207	1,908,300	0	28,255,899	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,595	354	164	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	724	0	1,616	0	26,741	192.00
192.01	19201	NONREIMBURSABLE	0	859	0	0	0	192.01
194.00	07950	CROSSTOWN SQUARE	0	0	1,024	0	131,031	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	0	194.03
194.04	07951	OUTREACH	0	0	0	0	0	194.04
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)	2,000,025	305,295	1,968,981	0	1,972,744	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.687791	5.824018	1.030285	0.000000	0.069429	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					4,865	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000171	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 9/11/2018 11:15 am

	Cost Center Description	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT (SQUARE FEET)	NEW CAP RELATED IRC (SQUARE FEET IRC)	NEW MVBLE EQUIP (DOLLAR VALUE)	MVBLE EQUIP IRC (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
		1.00	1.01	2.00	2.01	4.00	
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 9/11/2018 11:15 am

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT IRC (SQUARE FEET IRC)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
			5A	5.00	7.00	7.01	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-14,948,359	58,856,692				5.00
7.00	00700	OPERATION OF PLANT	0	3,193,317	154,172			7.00
7.01	00701	OPERATION OF PLANT IRC	0	13,063	0	50,177		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	61,203	2,394	181	573,679	8.00
9.00	00900	HOUSEKEEPING	0	670,707	1,092	396	0	9.00
10.00	01000	DIETARY	0	562,070	5,281	0	0	10.00
11.00	01100	CAFETERIA	0	25,473	2,932	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	920,957	780	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	802,536	6,688	0	2,823	14.00
15.00	01500	PHARMACY	0	2,218,419	4,640	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,030,984	2,752	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	9,591	1,104	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	6,783,080	43,014	0	110,681	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,313,204	3,740	0	15,834	31.00
43.00	04300	NURSERY	0	390,078	2,169	0	10,041	43.00
44.00	04400	SKILLED NURSING FACILITY	0	5,084,398	0	29,929	166,360	44.00
45.00	04500	NURSING FACILITY	0	537,475	0	14,419	12,140	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,233,124	16,107	0	92,892	50.00
53.00	05300	ANESTHESIOLOGY	0	63,175	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,870,218	8,858	0	34,683	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	286,123	0	0	0	55.00
57.00	05700	CT SCAN	0	505,006	0	0	16,428	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	137,751	182	0	3,061	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,053,772	2,408	0	6,824	59.00
60.00	06000	LABORATORY	0	6,152,660	14,984	0	66	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,487,520	2,812	0	4,271	65.00
66.00	06600	PHYSICAL THERAPY	0	2,414,379	3,386	4,039	5,376	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,569,679	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,513,968	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,850,053	0	0	0	73.00
76.00	03020	CARDIAC REHAB	0	601,560	8,700	0	241	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	21,903	0	0	0	90.00
90.01	09001	WOUND CENTER	0	413,166	1,893	0	0	90.01
91.00	09100	EMERGENCY	0	3,057,959	8,836	0	84,168	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	3,674,298	7,101	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-14,948,359	57,522,869	151,853	48,964	565,889	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,845	0	1,595	354	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	214,640	724	0	7,790	192.00
192.01	19201	NONREIMBURSABLE	0	54,669	0	859	0	192.01
194.00	07950	CROSSTOWN SQUARE	0	919,723	0	0	0	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	134,613	0	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	10,178	0	0	0	194.03
194.04	07951	OUTREACH	5,683	0	0	0	0	194.04
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)		14,948,359	4,004,352	16,381	138,986	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.253979	25.973277	0.326464	0.242271	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		936,629	524,314	13,271	31,023	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.015914	3.400838	0.264484	0.054077	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: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 9/11/2018 11:15 am

		Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT IRC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	140,569					9.00
10.00	01000	DIETARY	5,281	140,776				10.00
11.00	01100	CAFETERIA	2,932	112,336	47,490			11.00
13.00	01300	NURSING ADMINISTRATION	780	0	971	291,140		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,688	0	427	205	6,355,276	14.00
15.00	01500	PHARMACY	1,583	0	1,901	0	59,832	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,752	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,104	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	43,014	25,914	8,741	140,516	359,620	30.00
31.00	03100	INTENSIVE CARE UNIT	3,740	2,526	1,267	25,042	74,210	31.00
43.00	04300	NURSERY	2,169	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	6,597	0	208,287	44.00
45.00	04500	NURSING FACILITY	0	0	767	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,107	0	2,565	47,171	642,251	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	29,322	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,858	0	1,809	599	50,760	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	98	1	199,892	55.00
57.00	05700	CT SCAN	0	0	371	13	70,072	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	182	0	132	3	2,304	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,408	0	407	4,627	90,687	59.00
60.00	06000	LABORATORY	8,850	0	4,617	0	35,376	60.00
65.00	06500	RESPIRATORY THERAPY	2,812	0	1,861	6	97,331	65.00
66.00	06600	PHYSICAL THERAPY	4,039	0	2,838	0	13,137	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,390,728	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	2,633,247	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	5,908	0	614	4,711	6,390	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	28	259	0	90.00
90.01	09001	WOUND CENTER	1,893	0	264	4,673	39,613	90.01
91.00	09100	EMERGENCY	8,836	0	3,074	63,242	272,583	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	7,101	0	7,684	72	79,433	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	137,037	140,776	47,033	291,140	6,355,075	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,949	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	724	0	76	0	0	192.00
192.01	19201	NONREIMBURSABLE	859	0	0	0	0	192.01
194.00	07950	CROSSTOWN SQUARE	0	0	381	0	201	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	0	194.03
194.04	07951	OUTREACH	0	0	0	0	0	194.04
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)	869,544	874,657	824,190	1,196,797	1,230,381	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.185887	6.213112	17.355022	4.110727	0.193600	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	34,337	108,828	123,407	61,677	202,654	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.244271	0.773058	2.598589	0.211847	0.031888	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: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 9/11/2018 11:15 am

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)		
			15.00	16.00	17.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP RELATED IRC					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT IRC					7.01
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY	4,850,053				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	246,324,608			16.00
17.00	01700	SOCIAL SERVICE	0	0	10,882		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	16,137,104	9,147		30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,157,621	902		31.00
43.00	04300	NURSERY	0	0	833		43.00
44.00	04400	SKILLED NURSING FACILITY	0	7,722,358	0		44.00
45.00	04500	NURSING FACILITY	0	887,839	0		45.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	19,722,491	0		50.00
53.00	05300	ANESTHESIOLOGY	0	2,771,286	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,639,574	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,131,949	0		55.00
57.00	05700	CT SCAN	0	25,783,514	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	5,266,208	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	11,314,071	0		59.00
60.00	06000	LABORATORY	0	39,641,903	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	13,191,230	0		65.00
66.00	06600	PHYSICAL THERAPY	0	8,222,194	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14,571,166	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,850,053	23,996,877	0		73.00
76.00	03020	CARDIAC REHAB	0	1,056,303	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	53,066	0		90.00
90.01	09001	WOUND CENTER	0	3,580,599	0		90.01
91.00	09100	EMERGENCY	0	34,477,255	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,850,053	246,324,608	10,882		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
192.01	19201	NONREIMBURSABLE	0	0	0		192.01
194.00	07950	CROSSTOWN SQUARE	0	0	0		194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0		194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0		194.03
194.04	07951	OUTREACH	0	0	0		194.04
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)	2,956,734	1,381,334	47,530		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.609629	0.005608	4.367763		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	252,318	50,347	13,769		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.052024	0.000204	1.265300		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 9/11/2018 11:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,006,343		11,006,343	0	11,006,343	30.00
31.00	03100	INTENSIVE CARE UNIT	1,947,480		1,947,480	0	1,947,480	31.00
43.00	04300	NURSERY	564,974		564,974	0	564,974	43.00
44.00	04400	SKILLED NURSING FACILITY	6,623,926		6,623,926	0	6,623,926	44.00
45.00	04500	NURSING FACILITY	699,920		699,920	0	699,920	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,068,130		5,068,130	0	5,068,130	50.00
53.00	05300	ANESTHESIOLOGY	100,438		100,438	0	100,438	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,753,050		2,753,050	0	2,753,050	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	411,152		411,152	0	411,152	55.00
57.00	05700	CT SCAN	801,899		801,899	0	801,899	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	211,614		211,614	0	211,614	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,507,590		1,507,590	0	1,507,590	59.00
60.00	06000	LABORATORY	8,468,486		8,468,486	0	8,468,486	60.00
65.00	06500	RESPIRATORY THERAPY	2,081,928	0	2,081,928	0	2,081,928	65.00
66.00	06600	PHYSICAL THERAPY	3,241,040	0	3,241,040	0	3,241,040	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,319,305		2,319,305	0	2,319,305	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,662,261		3,662,261	0	3,662,261	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,173,173		9,173,173	0	9,173,173	73.00
76.00	03020	CARDIAC REHAB	1,054,099		1,054,099	0	1,054,099	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	29,315		29,315	0	29,315	90.00
90.01	09001	WOUND CENTER	630,518		630,518	0	630,518	90.01
91.00	09100	EMERGENCY	4,698,605		4,698,605	15	4,698,620	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,134,302		1,134,302		1,134,302	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,984,885		4,984,885	23	4,984,908	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	73,174,433	0	73,174,433	38	73,174,471	200.00
201.00		Less Observation Beds	1,134,302		1,134,302		1,134,302	201.00
202.00		Total (see instructions)	72,040,131	0	72,040,131	38	72,040,169	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 9/11/2018 11:15 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,304,910		13,304,910			30.00
31.00	03100	INTENSIVE CARE UNIT	3,041,829		3,041,829			31.00
43.00	04300	NURSERY	1,082,790		1,082,790			43.00
44.00	04400	SKILLED NURSING FACILITY	7,722,358		7,722,358			44.00
45.00	04500	NURSING FACILITY	887,839		887,839			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,446,084	12,739,941	19,186,025	0.264157	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	859,937	1,836,359	2,696,296	0.037250	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,626,179	10,707,641	12,333,820	0.223211	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	268,021	1,808,005	2,076,026	0.198048	0.000000	55.00
57.00	05700	CT SCAN	5,017,482	20,444,997	25,462,479	0.031493	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	322,858	4,749,733	5,072,591	0.041717	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,796,966	7,406,000	11,202,966	0.134571	0.000000	59.00
60.00	06000	LABORATORY	9,040,815	30,196,997	39,237,812	0.215825	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	6,930,261	5,445,139	12,375,400	0.168231	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,429,027	4,635,070	8,064,097	0.401910	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,379,767	3,132,337	5,512,104	0.420766	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,211,738	2,511,948	8,723,686	0.419807	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,853,672	14,958,593	23,812,265	0.385229	0.000000	73.00
76.00	03020	CARDIAC REHAB	22,967	1,023,656	1,046,623	1.007143	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	490	52,156	52,646	0.556832	0.000000	90.00
90.01	09001	WOUND CENTER	20,740	3,555,710	3,576,450	0.176297	0.000000	90.01
91.00	09100	EMERGENCY	4,694,227	19,331,242	24,025,469	0.195568	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	12,275	1,644,014	1,656,289	0.684845	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	10,749,876	10,749,876	0.463716	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	85,973,232	156,929,414	242,902,646			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	85,973,232	156,929,414	242,902,646			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 9/11/2018 11:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
45.00	04500	NURSING FACILITY		45.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.264157	50.00
53.00	05300	ANESTHESIOLOGY	0.037250	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.223211	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.198048	55.00
57.00	05700	CT SCAN	0.031493	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.041717	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.134571	59.00
60.00	06000	LABORATORY	0.215825	60.00
65.00	06500	RESPIRATORY THERAPY	0.168231	65.00
66.00	06600	PHYSICAL THERAPY	0.401910	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.420766	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.419807	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.385229	73.00
76.00	03020	CARDIAC REHAB	1.007143	76.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.556832	90.00
90.01	09001	WOUND CENTER	0.176297	90.01
91.00	09100	EMERGENCY	0.195568	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.684845	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.463718	95.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 9/11/2018 11:15 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	11,006,343		11,006,343	0	11,006,343	30.00
31.00	03100	INTENSIVE CARE UNIT	1,947,480		1,947,480	0	1,947,480	31.00
43.00	04300	NURSERY	564,974		564,974	0	564,974	43.00
44.00	04400	SKILLED NURSING FACILITY	6,623,926		6,623,926	0	6,623,926	44.00
45.00	04500	NURSING FACILITY	699,920		699,920	0	699,920	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,068,130		5,068,130	0	5,068,130	50.00
53.00	05300	ANESTHESIOLOGY	100,438		100,438	0	100,438	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,753,050		2,753,050	0	2,753,050	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	411,152		411,152	0	411,152	55.00
57.00	05700	CT SCAN	801,899		801,899	0	801,899	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	211,614		211,614	0	211,614	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,507,590		1,507,590	0	1,507,590	59.00
60.00	06000	LABORATORY	8,468,486		8,468,486	0	8,468,486	60.00
65.00	06500	RESPIRATORY THERAPY	2,081,928	0	2,081,928	0	2,081,928	65.00
66.00	06600	PHYSICAL THERAPY	3,241,040	0	3,241,040	0	3,241,040	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,319,305		2,319,305	0	2,319,305	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,662,261		3,662,261	0	3,662,261	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,173,173		9,173,173	0	9,173,173	73.00
76.00	03020	CARDIAC REHAB	1,054,099		1,054,099	0	1,054,099	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	29,315		29,315	0	29,315	90.00
90.01	09001	WOUND CENTER	630,518		630,518	0	630,518	90.01
91.00	09100	EMERGENCY	4,698,605		4,698,605	15	4,698,620	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,134,302		1,134,302		1,134,302	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,984,885		4,984,885	23	4,984,908	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	73,174,433	0	73,174,433	38	73,174,471	200.00
201.00		Less Observation Beds	1,134,302		1,134,302		1,134,302	201.00
202.00		Total (see instructions)	72,040,131	0	72,040,131	38	72,040,169	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 9/11/2018 11:15 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,304,910		13,304,910			30.00
31.00	03100	INTENSIVE CARE UNIT	3,041,829		3,041,829			31.00
43.00	04300	NURSERY	1,082,790		1,082,790			43.00
44.00	04400	SKILLED NURSING FACILITY	7,722,358		7,722,358			44.00
45.00	04500	NURSING FACILITY	887,839		887,839			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,446,084	12,739,941	19,186,025	0.264157	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	859,937	1,836,359	2,696,296	0.037250	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,626,179	10,707,641	12,333,820	0.223211	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	268,021	1,808,005	2,076,026	0.198048	0.000000	55.00
57.00	05700	CT SCAN	5,017,482	20,444,997	25,462,479	0.031493	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	322,858	4,749,733	5,072,591	0.041717	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,796,966	7,406,000	11,202,966	0.134571	0.000000	59.00
60.00	06000	LABORATORY	9,040,815	30,196,997	39,237,812	0.215825	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	6,930,261	5,445,139	12,375,400	0.168231	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,429,027	4,635,070	8,064,097	0.401910	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,379,767	3,132,337	5,512,104	0.420766	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,211,738	2,511,948	8,723,686	0.419807	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,853,672	14,958,593	23,812,265	0.385229	0.000000	73.00
76.00	03020	CARDIAC REHAB	22,967	1,023,656	1,046,623	1.007143	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	490	52,156	52,646	0.556832	0.000000	90.00
90.01	09001	WOUND CENTER	20,740	3,555,710	3,576,450	0.176297	0.000000	90.01
91.00	09100	EMERGENCY	4,694,227	19,331,242	24,025,469	0.195568	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	12,275	1,644,014	1,656,289	0.684845	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	10,749,876	10,749,876	0.463716	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	85,973,232	156,929,414	242,902,646			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	85,973,232	156,929,414	242,902,646			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 9/11/2018 11:15 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
45.00	04500	NURSING FACILITY		45.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
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	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03020	CARDIAC REHAB	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	WOUND CENTER	0.000000	90.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part I Date/Time Prepared: 9/11/2018 11:15 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	1,000,204	0	1,000,204	10,198	98.08	30.00
31.00	INTENSIVE CARE UNIT	129,974		129,974	902	144.10	31.00
43.00	NURSERY	34,606		34,606	833	41.54	43.00
44.00	SKILLED NURSING FACILITY	407,004		407,004	25,609	15.89	44.00
45.00	NURSING FACILITY	99,237		99,237	4,946	20.06	45.00
200.00	Total (lines 30 through 199)	1,671,025		1,671,025	42,488		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	3,519	345,144				30.00
31.00	INTENSIVE CARE UNIT	356	51,300				31.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	3,524	55,996				44.00
45.00	NURSING FACILITY	0	0				45.00
200.00	Total (lines 30 through 199)	7,399	452,440				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part II Date/Time Prepared: 9/11/2018 11:15 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	603,931	19,186,025	0.031478	2,482,031	78,129	50.00
53.00	05300	ANESTHESIOLOGY	36,004	2,696,296	0.013353	304,594	4,067	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	393,032	12,333,820	0.031866	485,028	15,456	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	11,629	2,076,026	0.005602	135,912	761	55.00
57.00	05700	CT SCAN	175,830	25,462,479	0.006905	1,201,349	8,295	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	26,143	5,072,591	0.005154	120,627	622	58.00
59.00	05900	CARDIAC CATHETERIZATION	74,292	11,202,966	0.006631	1,783,729	11,828	59.00
60.00	06000	LABORATORY	618,279	39,237,812	0.015757	3,021,025	47,602	60.00
65.00	06500	RESPIRATORY THERAPY	200,514	12,375,400	0.016203	3,091,605	50,093	65.00
66.00	06600	PHYSICAL THERAPY	432,954	8,064,097	0.053689	556,652	29,886	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	142,422	5,512,104	0.025838	990,669	25,597	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	123,973	8,723,686	0.014211	3,278,188	46,586	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	334,397	23,812,265	0.014043	3,652,767	51,296	73.00
76.00	03020	CARDIAC REHAB	191,595	1,046,623	0.183060	9,913	1,815	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,162	52,646	0.022072	112	2	90.00
90.01	09001	WOUND CENTER	85,721	3,576,450	0.023968	15,286	366	90.01
91.00	09100	EMERGENCY	303,837	24,025,469	0.012646	2,134,710	26,996	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	103,080	1,656,289	0.062236	7,675	478	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	3,858,795	206,113,044		23,271,872	399,875	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part III Date/Time Prepared: 9/11/2018 11:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
45.00	04500	NURSING FACILITY	0	0	0	0		45.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	10,198	0.00	3,519	30.00
31.00	03100	INTENSIVE CARE UNIT		0	902	0.00	356	31.00
43.00	04300	NURSERY		0	833	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	25,609	0.00	3,524	44.00
45.00	04500	NURSING FACILITY		0	4,946	0.00	0	45.00
200.00		Total (lines 30 through 199)		0	42,488		7,399	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost		
			9.00	13.00		
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0			44.00
45.00	04500	NURSING FACILITY	0			45.00
200.00		Total (lines 30 through 199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 9/11/2018 11:15 am

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		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
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	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CENTER	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 9/11/2018 11:15 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	19,186,025	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,696,296	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,333,820	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	2,076,026	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	25,462,479	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	5,072,591	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	11,202,966	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	39,237,812	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	12,375,400	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,064,097	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	5,512,104	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	8,723,686	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	23,812,265	0.000000	73.00
76.00	03020	CARDIAC REHAB	0	0	0	1,046,623	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	52,646	0.000000	90.00
90.01	09001	WOUND CENTER	0	0	0	3,576,450	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	24,025,469	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,656,289	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	206,113,044		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 9/11/2018 11:15 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	2,482,031	0	2,951,405	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	304,594	0	362,976	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	485,028	0	1,941,329	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	135,912	0	502,484	0	55.00
57.00	05700	CT SCAN	0.000000	1,201,349	0	5,153,983	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	120,627	0	880,232	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	1,783,729	0	3,211,144	0	59.00
60.00	06000	LABORATORY	0.000000	3,021,025	0	2,948,232	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	3,091,605	0	1,543,824	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	556,652	0	35,082	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	990,669	0	692,362	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	3,278,188	0	875,551	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	3,652,767	0	5,104,443	0	73.00
76.00	03020	CARDIAC REHAB	0.000000	9,913	0	438,077	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	112	0	437	0	90.00
90.01	09001	WOUND CENTER	0.000000	15,286	0	1,932,974	0	90.01
91.00	09100	EMERGENCY	0.000000	2,134,710	0	2,650,726	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	7,675	0	294,217	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		23,271,872	0	31,519,478	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 9/11/2018 11:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost		
			21.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
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	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	CARDIAC REHAB	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CENTER	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (lines 50 through 199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 9/11/2018 11:15 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	0.264157	2,951,405	0	0	779,634	50.00
53.00	05300	ANESTHESIOLOGY	0.037250	362,976	0	0	13,521	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.223211	1,941,329	0	0	433,326	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.198048	502,484	0	0	99,516	55.00
57.00	05700	CT SCAN	0.031493	5,153,983	0	0	162,314	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.041717	880,232	0	0	36,721	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.134571	3,211,144	0	0	432,127	59.00
60.00	06000	LABORATORY	0.215825	2,948,232	0	0	636,302	60.00
65.00	06500	RESPIRATORY THERAPY	0.168231	1,543,824	0	0	259,719	65.00
66.00	06600	PHYSICAL THERAPY	0.401910	35,082	0	0	14,100	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.420766	692,362	0	0	291,322	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.419807	875,551	0	0	367,562	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.385229	5,104,443	0	12,284	1,966,379	73.00
76.00	03020	CARDIAC REHAB	1.007143	438,077	0	0	441,206	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.556832	437	0	0	243	90.00
90.01	09001	WOUND CENTER	0.176297	1,932,974	0	0	340,778	90.01
91.00	09100	EMERGENCY	0.195568	2,650,726	0	0	518,397	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.684845	294,217	0	0	201,493	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.463716		0			95.00
200.00		Subtotal (see instructions)		31,519,478	0	12,284	6,994,660	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		31,519,478	0	12,284	6,994,660	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 9/11/2018 11:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
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	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,732		73.00
76.00	03020	CARDIAC REHAB	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CENTER	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	4,732		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	4,732		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0275 | Component CCN: 14-5703 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 9/11/2018 11:15 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
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	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CENTER	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0275 | Component CCN: 14-5703 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 9/11/2018 11:15 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	19,186,025	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,696,296	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,333,820	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	2,076,026	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	25,462,479	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	5,072,591	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	11,202,966	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	39,237,812	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	12,375,400	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,064,097	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	5,512,104	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	8,723,686	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	23,812,265	0.000000	73.00
76.00	03020	CARDIAC REHAB	0	0	0	1,046,623	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	52,646	0.000000	90.00
90.01	09001	WOUND CENTER	0	0	0	3,576,450	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	24,025,469	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,656,289	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	206,113,044		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0275 | Component CCN: 14-5703 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 9/11/2018 11:15 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
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	21,049	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	MAGNETIC RESONANCE IMAGING (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	58,026	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	45,648	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,074,698	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	280,075	0	0	0	73.00
76.00	03020	CARDIAC REHAB	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CENTER	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	24,983	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		1,504,479	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0275 | Component CCN: 14-5703 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 9/11/2018 11:15 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost	
			21.00	24.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
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	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03020	CARDIAC REHAB	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	WOUND CENTER	0	0	90.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (lines 50 through 199)	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 9/11/2018 11:15 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)	10,198	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	10,198	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)	9,147	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)	3,519	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)	11,006,343	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)	11,006,343	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)	11,006,343	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)	1,079.26	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,797,916	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)	3,797,916	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 9/11/2018 11:15 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	1,947,480	902	2,159.07	356	768,629	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	6,116,594	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	10,683,139	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)	396,444	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	399,875	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	796,319	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	9,886,820	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)	1,051	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,079.26	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,134,302	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 9/11/2018 11:15 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	1,000,204	11,006,343	0.090875	1,134,302	103,080	90.00
91.00	Nursing School cost	0	11,006,343	0.000000	1,134,302	0	91.00
92.00	Allied health cost	0	11,006,343	0.000000	1,134,302	0	92.00
93.00	All other Medical Education	0	11,006,343	0.000000	1,134,302	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0275 Component CCN: 14-5703	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 9/11/2018 11:15 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)	25,609	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	25,609	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)	25,609	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)	3,524	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)	6,623,926	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)	6,623,926	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)	6,623,926	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: 14-0275 | Component CCN: 14-5703 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 9/11/2018 11:15 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)	6,623,926	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	258.66	71.00
72.00	Program routine service cost (line 9 x line 71)	911,518	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)	911,518	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)	911,518	83.00
84.00	Program inpatient ancillary services (see instructions)	569,611	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)	1,481,129	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: 14-0275 Component CCN: 14-5703	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 9/11/2018 11:15 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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 9/11/2018 11:15 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		3,981,518		30.00
31.00	03100	INTENSIVE CARE UNIT		1,088,843		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.264157	2,482,031	655,646	50.00
53.00	05300	ANESTHESIOLOGY	0.037250	304,594	11,346	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.223211	485,028	108,264	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.198048	135,912	26,917	55.00
57.00	05700	CT SCAN	0.031493	1,201,349	37,834	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.041717	120,627	5,032	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.134571	1,783,729	240,038	59.00
60.00	06000	LABORATORY	0.215825	3,021,025	652,013	60.00
65.00	06500	RESPIRATORY THERAPY	0.168231	3,091,605	520,104	65.00
66.00	06600	PHYSICAL THERAPY	0.401910	556,652	223,724	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.420766	990,669	416,840	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.419807	3,278,188	1,376,206	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.385229	3,652,767	1,407,152	73.00
76.00	03020	CARDIAC REHAB	1.007143	9,913	9,984	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.556832	112	62	90.00
90.01	09001	WOUND CENTER	0.176297	15,286	2,695	90.01
91.00	09100	EMERGENCY	0.195568	2,134,710	417,481	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.684845	7,675	5,256	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		23,271,872	6,116,594	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)		23,271,872		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0275 | Component CCN: 14-5703 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 9/11/2018 11:15 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
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.264157	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.037250	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.223211	21,049	4,698	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.198048	0	0	55.00
57.00	05700	CT SCAN	0.031493	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.041717	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.134571	0	0	59.00
60.00	06000	LABORATORY	0.215825	58,026	12,523	60.00
65.00	06500	RESPIRATORY THERAPY	0.168231	45,648	7,679	65.00
66.00	06600	PHYSICAL THERAPY	0.401910	1,074,698	431,932	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.420766	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.419807	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.385229	280,075	107,893	73.00
76.00	03020	CARDIAC REHAB	1.007143	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.556832	0	0	90.00
90.01	09001	WOUND CENTER	0.176297	0	0	90.01
91.00	09100	EMERGENCY	0.195568	24,983	4,886	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.684845	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,504,479	569,611	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)		1,504,479		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0275	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 9/11/2018 11:15 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	2,510,619	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	7,531,858	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)	15,146	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	5,617,372	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	142.12	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	4.84	30.00
31.00	Percentage of Medicaid patient days (see instructions)	22.98	31.00
32.00	Sum of lines 30 and 31	27.82	32.00
33.00	Allowable disproportionate share percentage (see instructions)	12.17	33.00
34.00	Disproportionate share adjustment (see instructions)	305,543	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E Part A Date/Time Prepared: 9/11/2018 11:15 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)	593,434	629,367	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	149,578	470,732	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	620,310		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	10,983,476		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)		10,983,476	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		861,833	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		11,845,309	59.00
60.00	Primary payer payments		6,408	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		11,838,901	61.00
62.00	Deductibles billed to program beneficiaries		1,309,000	62.00
63.00	Coinsurance billed to program beneficiaries		14,225	63.00
64.00	Allowable bad debts (see instructions)		197,485	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		128,365	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		178,067	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		10,644,041	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)		-5,621	70.93
70.94	HRR adjustment amount (see instructions)		-27,495	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0275	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 9/11/2018 11:15 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)		89,772	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		10,521,153	71.00
71.01	Sequestration adjustment (see instructions)		210,423	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		10,167,358	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)		143,372	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

CALCULATION OF DSH PAYMENT PERCENTAGE | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet DSH | Date/Time Prepared: 9/11/2018 11:15 am

Title XVIII | Hospital | PPS

		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
	CALCULATION OF THE DSH PAYMENT PERCENTAGE						
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	4.84	0.00	0.00	4.84	4.84	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	22.98	0.00			22.98	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	27.82	0.00			27.82	3.00
4.00	Provider Type * (urban, rural,SCH, RRC, pickle - If pickle worksheet NA)	Urban				Urban	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	142.12	0.00			142.12	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	12.17	0.00			12.17	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	Yes				No	9.00
10.00	S-2, Line 45	Yes				Yes	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 geater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	4.84	0.00	0.00	4.84	4.84	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	No				No	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	14.00
	CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS						
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	483	0			483	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	353	0			353	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	5	0			5	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	10	0			10	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	1,645	0			1,645	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	29	0			29	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	2,525	0			2,525	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	10,882	0			10,882	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	0	0			0	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	108	0			108	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	10,990	0			10,990	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	22.98	0.00			22.98	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet DSH | Date/Time Prepared: 9/11/2018 11:15 am

Title XVIII | Hospital | PPS

		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE						
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	12.17		0.00	True	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	False	29.00
30.00	Line 28 or 29 as applicable		12.17		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		12.17		0.00		31.00

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

CALCULATION OF DSH PAYMENT PERCENTAGE	Provider CCN: 14-0275	Period: From 07/01/2017 To 06/30/2018	Worksheet DSH Date/Time Prepared: 9/11/2018 11:15 am
	Title XVIII	Hospital	PPS

		Revised Percentage 6.00		
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE			
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	12.17		28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	0.00		29.00
30.00	Line 28 or 29 as applicable	12.17		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	12.17		31.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0275	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 9/11/2018 11:15 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,732	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	6,994,660	2.00
3.00	OPPS payments	6,868,979	3.00
4.00	Outlier payment (see instructions)	24,255	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.274	5.00
6.00	Line 2 times line 5	1,916,537	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)	4,732	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	12,284	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)	12,284	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)	12,284	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	7,552	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)	4,732	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)	6,893,234	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)	1,295,050	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)	5,602,916	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)	5,602,916	30.00
31.00	Primary payer payments	2,655	31.00
32.00	Subtotal (line 30 minus line 31)	5,600,261	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)	188,972	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	122,832	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	153,758	36.00
37.00	Subtotal (see instructions)	5,723,093	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)	5,723,093	40.00
40.01	Sequestration adjustment (see instructions)	114,462	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	5,602,155	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	6,476	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: 14-0275	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 9/11/2018 11:15 am
	Title XVIII	Hospital	PPS

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 9/11/2018 11:15 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		10,167,358		5,602,155	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)		10,167,358		5,602,155	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		143,372		6,476	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		10,310,730		5,608,631	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: 14-0275	Period:	Worksheet E-1
Component CCN: 14-5703	From 07/01/2017	Part I
	To 06/30/2018	Date/Time Prepared: 9/11/2018 11:15 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		1,460,207		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)		1,460,207		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		1		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,460,208		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: 14-0275	Period: From 07/01/2017 To 06/30/2018	Worksheet E-1 Part II Date/Time Prepared: 9/11/2018 11:15 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
		Overrides	
		1.00	
	CONTRACTOR OVERRIDES		
108.00	Override of HIT payment		108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0275 Component CCN: 14-5703	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part VI Date/Time Prepared: 9/11/2018 11:15 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)	1,631,502	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,631,502	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	137,813	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)	1,493,689	12.00
13.00	Inpatient primary payer payments	3,681	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	1,490,008	15.00
15.01	Sequestration adjustment (see instructions)	29,800	15.01
15.02	Demonstration payment adjustment amount after sequestration	0	15.02
16.00	Interim payments	1,460,207	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)	1	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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G | Date/Time Prepared: 9/11/2018 11:15 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	29,689,298	0	0	0	1.00
2.00	Temporary investments	664,924	0	0	0	2.00
3.00	Notes receivable	1,886,365	0	0	0	3.00
4.00	Accounts receivable	39,135,824	0	0	0	4.00
5.00	Other receivable	547,268	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-23,027,269	0	0	0	6.00
7.00	Inventory	2,782,091	0	0	0	7.00
8.00	Prepaid expenses	719,861	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	5,469,366	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	57,867,728	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,362,122	0	0	0	12.00
13.00	Land improvements	5,304,039	0	0	0	13.00
14.00	Accumulated depreciation	-2,299,628	0	0	0	14.00
15.00	Buildings	69,523,765	0	0	0	15.00
16.00	Accumulated depreciation	-42,295,647	0	0	0	16.00
17.00	Leasehold improvements	2,090,594	0	0	0	17.00
18.00	Accumulated depreciation	-498,141	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	51,014,086	0	0	0	23.00
24.00	Accumulated depreciation	-44,215,270	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)	40,985,920	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	8,821,539	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	226,402	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	9,047,941	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	107,901,589	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,528,697	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,621,278	0	0	0	38.00
39.00	Payroll taxes payable	133,658	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,831,886	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	4,251,572	0	0	0	43.00
44.00	Other current liabilities	4,836,027	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	14,203,118	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	3,515,682	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	26,159	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	3,541,841	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	17,744,959	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	90,156,630				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)	90,156,630	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	107,901,589	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-1 | Date/Time Prepared: 9/11/2018 11:15 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		82,446,049		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		8,147,776				2.00
3.00	Total (sum of line 1 and line 2)		90,593,825		0		3.00
4.00	ADDITIONS	0		0		0	4.00
5.00	ROUNDING	0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		90,593,825		0		11.00
12.00	DEDUCTIONS	437,195		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)		437,195		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		90,156,630		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		0		4.00
5.00	ROUNDING		0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	DEDUCTIONS		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: 14-0275 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 9/11/2018 11:15 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	10,727,250		10,727,250	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	6,996,966		6,996,966	7.00
8.00	NURSING FACILITY	882,444		882,444	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	18,606,660		18,606,660	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	2,750,990		2,750,990	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)	2,750,990		2,750,990	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	21,357,650		21,357,650	17.00
18.00	Ancillary services	65,131,366	159,835,604	224,966,970	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	1,885	10,819,089	10,820,974	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	CROSSTOWN SQUARE	1,040,389	0	1,040,389	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	87,531,290	170,654,693	258,185,983	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		91,367,292		29.00
30.00	INCOME TAX	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	INCOME TAX	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		91,367,292		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-0275	Period: From 07/01/2017 To 06/30/2018	Worksheet G-3 Date/Time Prepared: 9/11/2018 11:15 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	258,185,983	1.00
2.00	Less contractual allowances and discounts on patients' accounts	154,054,821	2.00
3.00	Net patient revenues (line 1 minus line 2)	104,131,162	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	91,367,292	4.00
5.00	Net income from service to patients (line 3 minus line 4)	12,763,870	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	4,085,002	24.00
24.01	BAD DEBTS	-5,471,010	24.01
24.02	CHARITY CARE	-3,686,145	24.02
24.03	NONOPERATING GAINS & LOSSES	487,576	24.03
24.04	ROUNDING	0	24.04
24.05	ROUNDING	2	24.05
25.00	Total other income (sum of lines 6-24)	-4,584,575	25.00
26.00	Total (line 5 plus line 25)	8,179,295	26.00
27.00	COGS	31,519	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	31,519	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	8,147,776	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0275	Period: From 07/01/2017 To 06/30/2018	Worksheet L Parts I-III Date/Time Prepared: 9/11/2018 11:15 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	813,283	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	1,461	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)	27.83	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	4.84	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	22.98	8.00
9.00	Sum of lines 7 and 8	27.82	9.00
10.00	Allowable disproportionate share percentage (see instructions)	5.79	10.00
11.00	Disproportionate share adjustment (see instructions)	47,089	11.00
12.00	Total prospective capital payments (see instructions)	861,833	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