MARIANJOY REHAB HOSPITAL & CLINIC Provider CCN: 14-3027	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 08/31/2018	Run Date: 01/30/2019 Run Time: 11:30 Version: 2018.04 (06/21/2018)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY **WORKSHEET S**
PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report Date: 01/30/2019 Time: 11:30 2. [ ] Manually submitted cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted the cost report 4. [F] Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	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. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ___ 12. [ ] 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 MARIANJOY REHAB HOSPITAL & CLINIC (14-3027) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 07/01/2017 and ending 08/31/2018, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		-2,514,427	271			1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		-2,514,427	271			200

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 resopnd 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 this 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 this 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 appilcations, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any corresponence 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.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 26W171 ROOSEVELT ROAD	P.O. Box:		1
2	City: WHEATON	State: IL	ZIP Code: 60187	County: DUPAGE	2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	MARIANJOY REHAB HOSPITAL & CLINIC	14-3027	16974	5	01 / 01 / 1973	N	P	P	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF	MARIANJOY REHAB HOSPITAL & CLINIC	14-6129	16974		12 / 18 / 2008	N	P	N	9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2017	To: 08 / 31 / 2018	20
21	Type of control (see instructions)	2		21

Inpatient PPS Information		1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments 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§412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	N	N		22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
23	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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	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.							24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, 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.	1,151	511			588		25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	1			26
27	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
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.				35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.				37
37.01	Is this hospital a former MDH that is eilgible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N			37.01
38	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.	Beginning:		Ending:	38

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		1	2	
39	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
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40

		V	XVIII	XIX	
Prospective Payment System (PPS)-Capital		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	N	45
46	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
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	Y			56
57	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 Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
		NAHE 413.85 Y/N 1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3	
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions)	N			60
		Y/N 1	IME 4	Direct GME 5	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
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 baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathci 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

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.

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1	2	3	4	

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 direct the GME FTE unweighted count.

ACA Provisions Affecting the Health Resources and Services Administration (HRSA)

62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital reseived HRSA PCRE funding (see instructions)				62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01

Teaching Hospitals that Claim Residents in Nonprovider Settings

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64 through 67. (see instructions)	N			63

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

	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.	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	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 oolumn 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				64

Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. 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)

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65

	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	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)				66

Enter in lines 67-67.49, column 1 the program name. 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)

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67

Inpatient Psychiatric Faciltiy PPS		1	2	3	
70	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
71	If line 70 is yes: Column 1: Did the facility have a teaching program in the most recent cost report filed 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 and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				71

Inpatient Rehabilitation Facility PPS		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	Y			75
76	If line 75 is yes: Column 1: Did the facility have a 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 and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	Y	N		76

Long Term Care Hospital PPS				
80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.	N		80
81	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

TEFRA Providers				
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.	N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.			86
87	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter 'Y' for yes and 'N' for no.	N		87

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	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
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	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
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97
98	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06

Rural Providers		1	2	
105	Does this hospital qualify as a CAH?	N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elinination 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
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108

		Physical	Occupational	Speech	Respiratory	
109	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 each therapy.		N	N	N	109

		1	
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, compolete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110

		1	2	
111	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-healsh services.			111

Miscellaneous Cost Reporting Information

115	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-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.		N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.		Y		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		2		118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	238,161	1,026,035		118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
120	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
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.		N		121
122	Does the cost report contain state health care related taxes as defined in §1983(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

Transplant Center Information

125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N		125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date in column 2.			126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date in column 2.			127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date in column 2.			128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date in column 2.			129
130	If this is a Medicare cetfified pancreas transplant center enter the certification date in column 1 and termination date in column 2.			130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date in column 2.			131
132	If this is a Medicare cetfified islet transplant center enter the certification date in column 1 and termination date in column 2.			132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date in column 2.			133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.			134

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	Y	HB0640	140

If this facility is part of a chain organization, enter the name of the home office, the home office contractor name, and home office contractor number on line 141. Enter the address of the home office on lines 142 and 143.

141	Name: NORTHWESTERN MEMORIAL HEALTHCA	Contractor's Name: NGS		Contractor's Number: 00450		141
142	Street: 251 E HURON STREET	P.O. Box:				142
143	City: CHICAGO	State: 17	ZIP Code: 60611			143
144	Are provider based physicians' costs included in Worksheet A?				Y	144
145	If costs for renal services are claimed on Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.				Y	N 145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and '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
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.				N	147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.				N	148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.				N	149

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)

		Title XVIII				
		Part A	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N	N	N	156
157	Subprovider - IRF	N	N	N	N	157
158	Subprovider - Other					158
159	SNF	N	N	N	N	159
160	HHA	N	N	N	N	160
161	CMHC		N	N	N	161
161.10	CORF					161.10

Multicampus

165	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
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5. (see instructions)		166

	Name	County	State	ZIP Code	CBSA	FTE/Campus	
	0	1	2	3	4	5	

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	N		167
168	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)			168
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	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)			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170
171	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 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

		Y/N	Date		
Provider Organization and Operation		1	2		
1	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
		Y/N	Date	V/I	
		1	2	3	
2	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
3	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

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	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.	N			4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
Approved Educational Activities		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	Y		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructinos.	N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11

Bad Debts		Y/N	
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12
13	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
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14

Bed Complement			
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	01/03/2019	Y	01/03/2019	16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17
18	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 the cost report? If yes, see instructions.	N		N		18
19	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
20	If line 16 or 17 is yes, were adjustments made to PS&R Reoprt data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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 COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

Capital Related Cost			
22	Have assets been relifed for Medicare purposes? If yes, see instructions.		22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.		24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25
26	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.		27

Interest Expense			
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		28
29	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions.		29
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		31

Purchased Services			
32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33

Provider-Based Physicians			
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		34
35	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		35

		Y/N	Date	
Home Office Costs		1	2	
36	Are home office costs claimed on the cost report?			36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37
38	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38
39	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40

Cost Report Preparer Contact Information				
41	First name: VIKAS	Last name: CHOUDHARY	Title: ACCOUNTING & RIEMBURSEMENT	41
42	Employer: MARIANJOY REHABILITATION HOSPITAL			42
43	Phone number: 630-909-7309	E-mail Address: VCHOUDHARY@MARIANJOY.ORG		43

MARIANJOY REHAB HOSPITAL & CLINIC Provider CCN: 14-3027	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 08/31/2018	Run Date: 01/30/2019 Run Time: 11:30 Version: 2018.04 (06/21/2018)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						Inpatient Days / Outpatient Visits / Trips				
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	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	100	36,500			16,800	1,662	33,696	1
2	HMO and other (see instructions)						3,644	588		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF									5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		100	36,500			16,800	1,662	33,696	7
8	Intensive Care Unit	31								8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43								13
14	Total (see instructions)		100	36,500			16,800	1,662	33,696	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44	27	9,855			5,755	28	9,384	19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101								22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		127							27
28	Observation Bed Days									28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33
33.01	LTCH site neutral days and discharges									33.01

MARIANJOY REHAB HOSPITAL & CLINIC Provider CCN: 14-3027	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 08/31/2018	Run Date: 01/30/2019 Run Time: 11:30 Version: 2018.04 (06/21/2018)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		Full Time Equivalents			DISCHARGES				
	Component	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					1,204	119	2,278	1
2	HMO and other (see instructions)					227			2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)	13.85	586.13			1,204	119	2,278	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility		35.50						19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	Total (sum of lines 14-26)	13.85	621.63						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

MARIANJOY REHAB HOSPITAL & CLINIC Provider CCN: 14-3027	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 08/31/2018	Run Date: 01/30/2019 Run Time: 11:30 Version: 2018.04 (06/21/2018)

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

Part II - Wage Data

		Wkst A Line No.	Amount Reported	Reclassif-ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	Total salaries (see instructions)	200	46,001,375			1,292,990.00		1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetest Part B							3
4	Physician-Part A - Administrative							4
4.01	Physician-Part A - Teaching							4.01
5	Physician-Part B							5
6	Non-physician-Part B							6
7	Interns & residents (in an approved program)	21	1,128,243	46,474		36,025.00		7
7.01	Contracted interns & residents (in an approved program)							7.01
8	Home office and/or related organization personnel							8
9	SNF	44	2,392,647	-78,335		73,840.00		9
10	Excluded area salaries (see instructions)		6,270,541			163,946.00		10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)							11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative		538,839			3,810.00		13
14	Home office salaries & wage-related costs							14
14.01	Home office salaries		5,311,412			109,564.00		14.01
14.02	Related organization salaries							14.02
15	Home office: Physician Part A - Administrative							15
16	Home office & Contract Physicians Part A - Teaching							16
	WAGE-RELATED COSTS							
17	Wage-related costs (core)(see instructions)		9,577,756					17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		2,291,467					19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B							21
22	Physician Part A - Administrative							22
22.01	Physician Part A - Teaching							22.01
23	Physician Part B							23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)		298,427					25
25.50	Home office wage-related		-650,242					25.50
25.51	Related organization wage-related							25.51
25.52	Home office: Physician Part A - Administrative - wage-related							25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related							25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department		2,094,342			12,018.00		26
27	Administrative & General		7,067,505	-1,139,271		153,379.00		27
28	Administrative & General under contract (see instructions)							28
29	Maintenance & Repairs							29
30	Operation of Plant		384,644			19,094.00		30
31	Laundry & Linen Service							31
32	Housekeeping		790,155			50,523.00		32
33	Housekeeping under contract (see instructions)							33
34	Dietary		1,173,360	-431,718		39,811.00		34
35	Dietary under contract (see instructions)							35
36	Cafeteria			431,718		23,171.00		36
37	Maintenance of Personnel							37
38	Nursing Administration		210,315			5,408.00		38
39	Central Services and Supply		289,270			15,683.00		39
40	Pharmacy							40
41	Medical Records & Medical Records Library		324,474			12,730.00		41
42	Social Service			847,298		23,108.00		42
43	Other General Service		62,858			2,475.00		43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		44,873,132	-46,474	44,826,658	1,256,965.00	35.66	1
2	Excluded area salaries (see instructions)		8,663,188	-78,335	8,584,853	237,786.00	36.10	2
3	Subtotal salarles (line 1 minus line 2)		36,209,944	31,861	36,241,805	1,019,179.00	35.56	3
4	Subtotal other wages & related costs (see instructions)		5,850,251		5,850,251	113,374.00	51.60	4
5	Subtotal wage-related costs (see instructions)		8,927,514		8,927,514		24.63%	5
6	Total (sum of lines 3 through 5)		50,987,709	31,861	51,019,570	1,132,553.00	45.05	6
7	Total overhead cost (see instructions)		12,396,923	-291,973	12,104,950	357,400.00	33.87	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions	3,009,708	1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)		8
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		8.02
8.03	Health Insurance (Purchased)	3,525,422	8.03
9	Prescription Drug Plan	1,458,522	9
10	Dental, Hearing and Vision Plan	185,954	10
11	Life Insurance (If employee is owner or beneficiary)	53,082	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	372,839	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance		15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-Employers Portion Only	3,298,920	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	125,100	19
20	State or Federal Unemployment Taxes		20
	OTHER		
21	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	Day Care Costs and Allowances		22
23	Tuition Reimbursement	138,104	23
24	Total Wage Related cost (Sum of lines 1-23)	12,167,651	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25

MARIANJOY REHAB HOSPITAL & CLINIC Provider CCN: 14-3027	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 08/31/2018	Run Date: 01/30/2019 Run Time: 11:30 Version: 2018.04 (06/21/2018)

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost			1
2	Hospital			2
3	Subprovider - IPF			3
4	Subprovider - IRF			4
5	Subprovider - (OTHER)			5
6	Swing Beds - SNF			6
7	Swing Beds - NF			7
8	Hospital-Based SNF			8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
13	Hospital-Based Hospice			13
14	Hospital-Based Health Clinic - RHC			14
15	Hospital-Based Health Clinic - FQHC			15
16	Hospital-Based - CMHC			16
17	Renal Dialysis			17
18	Other			18

MARIANJOY REHAB HOSPITAL & CLINIC Provider CCN: 14-3027	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 08/31/2018	Run Date: 01/30/2019 Run Time: 11:30 Version: 2018.04 (06/21/2018)

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA **WORKSHEET S-7**

		Y/N	DATE	
		1	2	
1	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter 'Y' for yes and do not complete the rest of this worksheet.	N		1
2	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

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
3	RUX				3
4	RUL				4
5	RVX				5
6	RVL				6
7	RHX				7
8	RHL				8
9	RMX				9
10	RML				10
11	RLX				11
12	RUC	13		13	12
13	RUB	352		352	13
14	RUA	5,000		5,000	14
15	RVC	14		14	15
16	RVB	31		31	16
17	RVA	276		276	17
18	RHC				18
19	RHB	1		1	19
20	RHA	33		33	20
21	RMC				21
22	RMB				22
23	RMA				23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1				28
29	HE2				29
30	HE1				30
31	HD2				31
32	HD1				32
33	HC2				33
34	HC1				34
35	HB2				35
36	HB1	1		1	36
37	LE2				37
38	LE1				38
39	LD2				39
40	LD1				40
41	LC2				41
42	LC1				42
43	LB2				43
44	LB1				44
45	CE2				45
46	CE1				46
47	CD2				47
48	CD1				48
49	CC2				49
50	CC1	5		5	50
51	CB2				51
52	CB1	16		16	52
53	CA2				53
54	CA1	2		2	54
55	SE3				55
56	SE2				56
57	SE1				57
58	SSC				58
59	SSB				59
60	SSA				60
61	IB2				61
62	IB1				62
63	IA1				63
64	IA2				64
65	BB2				65
66	BB1				66
67	BA2				67
68	BA1				68
69	PE2				69

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA **WORKSHEET S-7**

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
70	PE1				70
71	PD2				71
72	PD1				72
73	PC2				73
74	PC1	1		1	74
75	PB2				75
76	PB1	4		4	76
77	PA2				77
78	PA1	6		6	78
199	AAA				199
200	TOTAL	5,755		5,755	200

SNF SERVICES

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1	2	
201	Enter in column 1 the SNF CBSA code, or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2 the code in effect on or after October 1 of the cost reporting period (if applicable).	16974		201

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 catetory. 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' or 'N' for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1	2	3	
202	Staffing	2,894,620	18.28%	Y	202
203	Recruitment				203
204	Retention of employees				204
205	Training	6,211	0.04%	Y	205
206	Other (ALL OTHER APPLICAPLE EXPENSE)	285,293	1.80%	Y	206
207	Total SNF Revenue (Worksheet G-2, Part I, line 7, column 3)	15,835,566			207

MARIANJOY REHAB HOSPITAL & CLINIC Provider CCN: 14-3027	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 08/31/2018	Run Date: 01/30/2019 Run Time: 11:30 Version: 2018.04 (06/21/2018)

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES **WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		3,144,951	3,144,951		3,144,951		3,144,951	1
2	00200	Cap Rel Costs-Mvble Equip		879,449	879,449		879,449		879,449	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	2,094,342	69,652	2,163,994	20,985	2,184,979		2,184,979	4
5.01	00590	A&G NON INTERN & NON RESIDENT	3,133,553	6,554,335	9,687,888	-702,475	8,985,413	-3,107,735	5,877,678	5.01
5.02	00560	A&G PURCHASING & RECEIVING	163,030	156,133	319,163	6,540	325,703		325,703	5.02
5.03	00570	A&G ADMITTING	1,313,452	374,863	1,688,315	-804,072	884,243		884,243	5.03
5.04	00580	A&G PFS CASHIER/ACCTS RECEIVABLE								5.04
5.05	00591	A&G OTHER INTERN & RESIDENT RELATED	2,457,470	11,442,937	13,900,407	195,801	14,096,208	1,166,062	15,262,270	5.05
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	384,644	3,929,111	4,313,755	-674,687	3,639,068	-211,952	3,427,116	7
8	00800	Laundry & Linen Service								8
9	00900	Housekeeping	790,155	878,673	1,668,828	24,524	1,693,352		1,693,352	9
10	01000	Dietary	1,173,360	1,645,740	2,819,100	-974,704	1,844,396		1,844,396	10
11	01100	Cafeteria				1,037,240	1,037,240	-583,048	454,192	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	210,315	69,688	280,003		280,003		280,003	13
14	01400	Central Services & Supply	289,270	365,304	654,574		654,574		654,574	14
15	01500	Pharmacy								15
16	01600	Medical Records & Library	324,474	130,837	455,311	27,453	482,764	-150	482,614	16
17	01700	Social Service				1,061,495	1,061,495		1,061,495	17
18	01850	OTHER GENERAL SERVICE (SPECIFY)	62,858	24,778	87,636		87,636		87,636	18
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd	1,128,243	783,096	1,911,339	76,742	1,988,081	-133,243	1,854,838	21
22	02200	I&R Services-Other Prgm Costs Apprvd				45,395	45,395		45,395	22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	12,415,349	4,889,140	17,304,489	-802,393	16,502,096	-199,899	16,302,197	30
44	04400	Skilled Nursing Facility	2,392,647	793,478	3,186,125	-102,810	3,083,315		3,083,315	44
		ANCILLARY SERVICE COST CENTERS								
54	05400	Radiology-Diagnostic	102,840	96,188	199,028	1,204,259	1,403,287		1,403,287	54
60	06000	Laboratory		367,343	367,343	189,418	556,761		556,761	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	223,323	139,303	362,626	-9,510	353,116		353,116	65
66	06600	Physical Therapy	2,450,239	728,790	3,179,029		3,179,029	-55,176	3,123,853	66
67	06700	Occupational Therapy	1,908,631	487,422	2,396,053	1,192	2,397,245		2,397,245	67
68	06800	Speech Pathology	1,350,891	334,406	1,685,297	1,703	1,687,000		1,687,000	68
71	07100	Medical Supplies Charged to Patients		195,137	195,137	53,678	248,815	979	249,794	71
73	07300	Drugs Charged to Patients	1,154,092	1,025,140	2,179,232	-22,382	2,156,850		2,156,850	73
74	07400	Renal Dialysis		321,532	321,532		321,532		321,532	74
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90.01	09001	WHEATON OUTPATIENT	2,270,156	677,612	2,947,768	196,801	3,144,569	-7,993	3,136,576	90.01
90.02	09002	OTHER DAY HOSPITAL	1,937,500	615,867	2,553,367	-55,643	2,497,724	-1,700	2,496,024	90.02
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	39,730,834	41,120,905	80,851,739	-5,450	80,846,289	-3,133,855	77,712,434	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen								190
191	19100	Research	83,704	31,934	115,638	5,450	121,088		121,088	191
191.01	19101	CONTRACT MNGMT & JOINT VENTURE	6,186,837	1,744,342	7,931,179		7,931,179		7,931,179	191.01
200		TOTAL (sum of lines 118-199)	46,001,375	42,897,181	88,898,556		88,898,556	-3,133,855	85,764,701	200

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	DIETARY	B	Cafeteria	11	431,718	605,522	1
500	Total reclassifications				431,718	605,522	500
	Code Letter - B						
1	MEDICAL SUPPLIES	C	Medical Supplies Charged to P	71		53,678	1
2	MEDICAL SUPPLIES	C					2
3	MEDICAL SUPPLIES	C					3
4	MEDICAL SUPPLIES	C					4
5	MEDICAL SUPPLIES	C					5
6	MEDICAL SUPPLIES	C					6
7	MEDICAL SUPPLIES	C					7
8	MEDICAL SUPPLIES	C					8
9	MEDICAL SUPPLIES	C					9
500	Total reclassifications					53,678	500
	Code Letter - C						
1	PATIENT SCHEDULING	D	Adults & Pediatrics	30	375,112	179,433	1
2	PATIENT SCHEDULING	D	WHEATON OUTPATIENT	90.01	75,865	36,290	2
500	Total reclassifications				450,977	215,723	500
	Code Letter - D						
1	STAFF RECLASS	E	Social Service	17	847,298	214,197	1
2	STAFF RECLASS	E					2
3	STAFF RECLASS	E					3
4	STAFF RECLASS	E					4
5	STAFF RECLASS	E					5
500	Total reclassifications				847,298	214,197	500
	Code Letter - E						
1	CROSS DEPARTMENT	F	Radiology-Diagnostic	54	957,665	242,098	1
2	CROSS DEPARTMENT	F	Laboratory	60	151,196	38,222	2
3	CROSS DEPARTMENT	F	Respiratory Therapy	65	871	220	3
500	Total reclassifications				1,109,732	280,540	500
	Code Letter - F						
1	SPACE	G	Employee Benefits Department	4		20,985	1
2	SPACE	G	A&G NON INTERN & NON RESIDENT	5.01		76,995	2
3	SPACE	G	A&G PURCHASING & RECEIVING	5.02		6,540	3
4	SPACE	G					4
5	SPACE	G	A&G OTHER INTERN & RESIDENT R	5.05		195,801	5
6	SPACE	G	Operation of Plant	7		68,429	6
7	SPACE	G	Housekeeping	9		24,524	7
8	SPACE	G	Dietary	10		62,536	8
9	SPACE	G	Medical Records & Library	16		27,453	9
10	SPACE	G	I&R Services-Salary & Fringes	21		9,367	10
11	SPACE	G	Adults & Pediatrics	30		48,469	11
12	SPACE	G	Radiology-Diagnostic	54		4,496	12
13	SPACE	G	Occupational Therapy	67		1,192	13
14	SPACE	G	Speech Pathology	68		1,703	14
15	SPACE	G	WHEATON OUTPATIENT	90.01		189,176	15
16	SPACE	G	Research	191		5,450	16
500	Total reclassifications					743,116	500
	Code Letter - G						
1	LIBRARY	I	I&R Services-Salary & Fringes	21	46,474		1
2	LIBRARY	I	I&R Services-Salary & Fringes	21		20,901	2
3			I&R Services-Other Prgm Costs	22		45,395	3
500	Total reclassifications				46,474	66,296	500
	Code Letter - I						
	GRAND TOTAL (Increases)				2,886,199	2,179,072	

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	DIETARY	B	Dietary	10	431,718	605,522		1
500	Total reclassifications				431,718	605,522		500
	Code letter - B							
1	MEDICAL SUPPLIES	C	Adults & Pediatrics	30		15,135		1
2	MEDICAL SUPPLIES	C	Skilled Nursing Facility	44		4,672		2
3	MEDICAL SUPPLIES	C	Respiratory Therapy	65		10,601		3
4	MEDICAL SUPPLIES	C						4
5	MEDICAL SUPPLIES	C	Drugs Charged to Patients	73		22,382		5
6	MEDICAL SUPPLIES	C	WHEATON OUTPATIENT	90.01		836		6
7	MEDICAL SUPPLIES	C	OTHER DAY HOSPITAL	90.02		52		7
8	MEDICAL SUPPLIES	C						8
9	MEDICAL SUPPLIES	C						9
500	Total reclassifications					53,678		500
	Code letter - C							
1	PATIENT SCHEDULING	D	A&G NON INTERN & NON RESIDENT	5.01	450,977	215,723		1
2	PATIENT SCHEDULING	D						2
500	Total reclassifications				450,977	215,723		500
	Code letter - D							
1	STAFF RECLASS	E	A&G ADMITTING	5.03	641,820	162,252		1
2	STAFF RECLASS	E	Skilled Nursing Facility	44	78,335	19,803		2
3	STAFF RECLASS	E	WHEATON OUTPATIENT	90.01	82,770	20,924		3
4	STAFF RECLASS	E	OTHER DAY HOSPITAL	90.02	44,373	11,218		4
5	STAFF RECLASS	E						5
500	Total reclassifications				847,298	214,197		500
	Code letter - E							
1	CROSS DEPARTMENT	F	Adults & Pediatrics	30	1,109,732	280,540		1
2	CROSS DEPARTMENT	F						2
3	CROSS DEPARTMENT	F						3
500	Total reclassifications				1,109,732	280,540		500
	Code letter - F							
1	SPACE	G	Operation of Plant	7		743,116		1
2	SPACE	G						2
3	SPACE	G						3
4	SPACE	G						4
5	SPACE	G						5
6	SPACE	G						6
7	SPACE	G						7
8	SPACE	G						8
9	SPACE	G						9
10	SPACE	G						10
11	SPACE	G						11
12	SPACE	G						12
13	SPACE	G						13
14	SPACE	G						14
15	SPACE	G						15
16	SPACE	G						16
500	Total reclassifications					743,116		500
	Code letter - G							
1	LIBRARY	I	A&G NON INTERN & NON RESIDENT	5.01	46,474	66,296		1
2	LIBRARY	I						2
3								3
500	Total reclassifications				46,474	66,296		500
	Code letter - I							
	GRAND TOTAL (Decreases)				2,886,199	2,179,072		

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			Acquisitions						
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	6,800,000					6,800,000		1
2	Land Improvements								2
3	Buildings and Fixtures	61,757,000	1,111,000		1,111,000		62,868,000		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	4,964,000	1,478,000		1,478,000		6,442,000		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	73,521,000	2,589,000		2,589,000		76,110,000		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	73,521,000	2,589,000		2,589,000		76,110,000		10

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 AND 2

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	3,144,951						3,144,951	1
2	Cap Rel Costs-Mvble Equip	879,449						879,449	2
3	Total (sum of lines 1-2)	4,024,400						4,024,400	3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2.

* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	69,668,000		69,668,000	0.915359					1
2	Cap Rel Costs-Mvble Equ	6,442,000		6,442,000	0.084641					2
3	Total (sum of lines 1-2)	76,110,000		76,110,000	1.000000					3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	3,144,951						3,144,951	1
2	Cap Rel Costs-Mvble Equip	879,449						879,449	2
3	Total (sum of lines 1-2)	4,024,400						4,024,400	3

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1		1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)						7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-154,518				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	1,253,225				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-583,048	Cafeteria	11		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts	B	-150	Medical Records & Library	16		18
19	Nursing and allied health education (tuition, fees, books, etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33							33
33.02	OPERATING REVENUE	B	623,355	A&G NON INTERN & NON RESIDENT	5.01		33.02
33.03	OPERATING REVENUE	B	-87,038	A&G OTHER INTERN & RESIDENT RELATED	5.05		33.03
33.04	OPERATING REVENUE	B	-211,952	Operation of Plant	7		33.04
33.05	OPERATING REVENUE	B	-133,243	I&R Services-Salary & Fringes Apprvd	21		33.05
33.08	OPERATING REVENUE	B	-45,381	Adults & Pediatrics	30		33.08
33.09	OPERATING REVENUE	B	-55,176	Physical Therapy	66		33.09
33.10	OPERATING REVENUE	B	979	Medical Supplies Charged to Patients	71		33.10
33.11	OPERATING REVENUE	B	-7,993	WHEATON OUTPATIENT	90.01		33.11
33.12	OPERATING REVENUE	B	-1,700	OTHER DAY HOSPITAL	90.02		33.12
34							34
34.01	IDPA ASSESSMENTS	A	-3,578,600	A&G NON INTERN & NON RESIDENT	5.01		34.01
34.03	TRANSPORTATION EXPENSE	A	-136,626	A&G NON INTERN & NON RESIDENT	5.01		34.03
35	FUNDRAISING	A	-1,755	A&G NON INTERN & NON RESIDENT	5.01		35
36	MARKETING	A	-125	A&G OTHER INTERN & RESIDENT RELATED	5.05		36
37	OTHER NON-ALLOWABLE COST	A	-14,109	A&G NON INTERN & NON RESIDENT	5.01		37
38							38
39							39
40							40
41							41
42							42
43							43
44							44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-3,133,855				50

MARIANJOY REHAB HOSPITAL & CLINIC Provider CCN: 14-3027	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 08/31/2018	Run Date: 01/30/2019 Run Time: 11:30 Version: 2018.04 (06/21/2018)

ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	

(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.

MARIANJOY REHAB HOSPITAL & CLINIC Provider CCN: 14-3027	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 08/31/2018	Run Date: 01/30/2019 Run Time: 11:30 Version: 2018.04 (06/21/2018)

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS **WORKSHEET A-8-1**

A: COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1								1
2	5.05	A&G OTHER INTERN & RESIDENT RELATED	NMHC HOME OFFICE	9,964,891	8,711,666	1,253,225		2
3								3
4	5.05	A&G OTHER INTERN & RESIDENT RELATED	INSURANCE	231,196	231,196			4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			10,196,087	8,942,862	1,253,225		5

* The amounts on lines 1 through 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 have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

B. INTERRELATIONSHIP OF 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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6	B	OLA	100.00	OLA	100.00	MOTHER HOUSE	6
7	B	WFH	100.00	WFH	100.00	CORPORATE OFFIC	7
8	B	WFH SE WI	100.00	WFH SE WI	100.00	LAUNDRY SERVICE	8
9	B	NMH	100.00	NMH	100.00	CORPORATE OFFIC	9
10							10

(1) Use the following symbols to indicate the 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.
G. Other (financial Or non-financial) specify:

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun-eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	30	Adults & Pediatrics NMHC PHYSICIANS	338,854		338,854	179,000	2,142	184,336	9,217	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	338,854		338,854		2,142	184,336	9,217	200

PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	30	Adults & Pediatrics NMHC PHYSICIANS					184,336	154,518	154,518	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					184,336	154,518	154,518	200

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	A&G NON IN TERN & NON RESIDENT	A&G PURCHA SING & REC EIVING	
		0	1	2	4	5.01	5.02	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	3,144,951	3,144,951					1
2	Cap Rel Costs-Mvble Equip	879,449		879,449				2
4	Employee Benefits Department	2,184,979		1,171	2,186,150			4
5.01	A&G NON INTERN & NON RESIDENT	5,877,678	47,157	82,436	131,252	6,138,523		5.01
5.02	A&G PURCHASING & RECEIVING	325,703		830	8,117		334,650	5.02
5.03	A&G ADMITTING	884,243	38,431	2,699	33,441		4	5.03
5.04	A&G PFS CASHIER/ACCTS RECEIVABLE							5.04
5.05	A&G OTHER INTERN & RESIDENT RELATED	15,262,270	53,649	8,255	122,357		3,685	5.05
6	Maintenance & Repairs							6
7	Operation of Plant	3,427,116	264,583	160,503	19,151		2,223	7
8	Laundry & Linen Service							8
9	Housekeeping	1,693,352	26,969	101,868	39,342		176	9
10	Dietary	1,844,396	111,959	22,509	36,926		1,348	10
11	Cafeteria	454,192			21,495			11
12	Maintenance of Personnel							12
13	Nursing Administration	280,003		40	10,472		11	13
14	Central Services & Supply	654,574	121,186		14,403		5,894	14
15	Pharmacy							15
16	Medical Records & Library	482,614			16,156		185	16
17	Social Service	1,061,495			42,187			17
18	OTHER GENERAL SERVICE (SPECIFY)	87,636	13,927		3,130			18
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	1,854,838			58,489		170	21
22	I&R Services-Other Prgm Costs Apprvd	45,395						22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	16,302,197	1,779,500	124,707	581,600	2,350,918	118,442	30
44	Skilled Nursing Facility	3,083,315	300,510		115,230	970,863	17,639	44
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	1,403,287		28,134	52,803	21,788	1	54
60	Laboratory	556,761			7,528	214,897	2,763	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	353,116		2,341	11,163	122,807	14,069	65
66	Physical Therapy	3,123,853	149,465	8,381	121,997	707,201	1,072	66
67	Occupational Therapy	2,397,245	130,934	404	95,031	685,782	2,471	67
68	Speech Pathology	1,687,000	39,760	49,415	67,261	442,414	1,684	68
71	Medical Supplies Charged to Patients	249,794				125,319	19,677	71
73	Drugs Charged to Patients	2,156,850	56,692	32,438	57,462	467,911	132,154	73
74	Renal Dialysis	321,532				28,623		74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	WHEATON OUTPATIENT	3,136,576		61,558	112,687		6,958	90.01
90.02	OTHER DAY HOSPITAL	2,496,024		31,407	94,259		2,740	90.02
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	77,712,434	3,134,722	719,096	1,873,939	6,138,523	333,366	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		10,229					190
191	Research	121,088		147,745	4,168		45	191
191.01	CONTRACT MNGMT & JOINT VENTURE	7,931,179		12,608	308,043		1,239	191.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	85,764,701	3,144,951	879,449	2,186,150	6,138,523	334,650	202

MARIANJOY REHAB HOSPITAL & CLINIC Provider CCN: 14-3027	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 08/31/2018	Run Date: 01/30/2019 Run Time: 11:30 Version: 2018.04 (06/21/2018)

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	A&G ADMITTING	SUBTOTAL (cols.0-4)	A&G OTHER INTERN & RESIDENT RE	OPERATION OF PLANT	HOUSE-KEEPING	DIETARY	
		5.03	4A	5.05	7	9	10	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	A&G NON INTERN & NON RESIDENT							5.01
5.02	A&G PURCHASING & RECEIVING							5.02
5.03	A&G ADMITTING	958,818						5.03
5.04	A&G PFS CASHIER/ACCTS RECEIVABLE							5.04
5.05	A&G OTHER INTERN & RESIDENT RELATED		15,450,216	15,450,216				5.05
6	Maintenance & Repairs							6
7	Operation of Plant		3,873,576	851,141	4,724,717			7
8	Laundry & Linen Service							8
9	Housekeeping		1,861,707	409,073	46,484	2,317,264		9
10	Dietary		2,017,138	443,226	192,977	95,587	2,748,928	10
11	Cafeteria		475,687	104,523				11
12	Maintenance of Personnel							12
13	Nursing Administration		290,526	63,837				13
14	Central Services & Supply		796,057	174,918	208,881	103,465		14
15	Pharmacy							15
16	Medical Records & Library		498,955	109,635				16
17	Social Service		1,103,682	242,512				17
18	OTHER GENERAL SERVICE (SPECIFY)		104,693	23,004	24,006	11,891		18
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		1,913,497	420,453				21
22	I&R Services-Other Prgm Costs Apprvd		45,395	9,975				22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	315,646	21,573,010	4,740,250	3,067,214	1,519,279	2,150,136	30
44	Skilled Nursing Facility	130,374	4,617,931	1,014,698	517,970	256,566	598,792	44
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	2,926	1,508,939	331,559				54
60	Laboratory	28,858	810,807	178,159				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	16,491	519,987	114,257				65
66	Physical Therapy	97,718	4,209,687	924,995	257,624	127,608		66
67	Occupational Therapy	92,092	3,403,959	747,952	225,682	111,787		67
68	Speech Pathology	60,062	2,347,596	515,837	68,531	33,946		68
71	Medical Supplies Charged to Patients	16,829	411,619	90,445				71
73	Drugs Charged to Patients	62,834	2,966,341	651,794	97,717	48,402		73
74	Renal Dialysis	3,844	353,999	77,784				74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	WHEATON OUTPATIENT	78,161	3,395,940	746,190				90.01
90.02	OTHER DAY HOSPITAL	52,983	2,677,413	588,308				90.02
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	958,818	77,228,357	13,574,525	4,707,086	2,308,531	2,748,928	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		10,229	2,248	17,631	8,733		190
191	Research		273,046	59,996				191
191.01	CONTRACT MNGMT & JOINT VENTURE		8,253,069	1,813,447				191.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	958,818	85,764,701	15,450,216	4,724,717	2,317,264	2,748,928	202

MARIANJOY REHAB HOSPITAL & CLINIC Provider CCN: 14-3027	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 08/31/2018	Run Date: 01/30/2019 Run Time: 11:30 Version: 2018.04 (06/21/2018)

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE	
		11	13	14	16	17	18	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	A&G NON INTERN & NON RESIDENT							5.01
5.02	A&G PURCHASING & RECEIVING							5.02
5.03	A&G ADMITTING							5.03
5.04	A&G PFS CASHIER/ACCTS RECEIVABLE							5.04
5.05	A&G OTHER INTERN & RESIDENT RELATED							5.05
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria	580,210						11
12	Maintenance of Personnel							12
13	Nursing Administration	3,122	357,485					13
14	Central Services & Supply	9,054		1,292,375				14
15	Pharmacy							15
16	Medical Records & Library	7,349		777	616,716			16
17	Social Service					1,346,194		17
18	OTHER GENERAL SERVICE (SPECIFY)	1,429					165,023	18
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	20,799		711				21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	228,592	357,485	496,484	203,064	1,346,194	165,023	30
44	Skilled Nursing Facility	42,630		73,937	83,849			44
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	1,501		4	1,882			54
60	Laboratory			11,584	18,560			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	4,047		4,493	10,606			65
66	Physical Therapy	43,603		4,493	62,846			66
67	Occupational Therapy	28,027		10,357	59,228			67
68	Speech Pathology	18,133		7,057	38,629			68
71	Medical Supplies Charged to Patients			82,483	10,823			71
73	Drugs Charged to Patients	13,905		553,960	40,412			73
74	Renal Dialysis				2,472			74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	WHEATON OUTPATIENT	33,599		29,166	50,269			90.01
90.02	OTHER DAY HOSPITAL	29,769		11,487	34,076			90.02
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	485,559	357,485	1,286,993	616,716	1,346,194	165,023	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
191	Research	1,153		188				191
191.01	CONTRACT MNGMT & JOINT VENTURE	93,498		5,194				191.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	580,210	357,485	1,292,375	616,716	1,346,194	165,023	202

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	I&R SALARY & FRINGES	I&R PROGRAM COSTS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		21	22	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	A&G NON INTERN & NON RESIDENT							5.01
5.02	A&G PURCHASING & RECEIVING							5.02
5.03	A&G ADMITTING							5.03
5.04	A&G PFS CASHIER/ACCTS RECEIVABLE							5.04
5.05	A&G OTHER INTERN & RESIDENT RELATED							5.05
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
18	OTHER GENERAL SERVICE (SPECIFY)							18
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	2,355,460						21
22	I&R Services-Other Prgm Costs Apprvd		55,370					22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	2,355,460	55,370	38,257,561	-2,410,830	35,846,731		30
44	Skilled Nursing Facility			7,206,373		7,206,373		44
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic			1,843,885		1,843,885		54
60	Laboratory			1,019,110		1,019,110		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			653,390		653,390		65
66	Physical Therapy			5,630,856		5,630,856		66
67	Occupational Therapy			4,586,992		4,586,992		67
68	Speech Pathology			3,029,729		3,029,729		68
71	Medical Supplies Charged to Patients			595,370		595,370		71
73	Drugs Charged to Patients			4,372,531		4,372,531		73
74	Renal Dialysis			434,255		434,255		74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	WHEATON OUTPATIENT			4,255,164		4,255,164		90.01
90.02	OTHER DAY HOSPITAL			3,341,053		3,341,053		90.02
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	2,355,460	55,370	75,226,269	-2,410,830	72,815,439		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen			38,841		38,841		190
191	Research			334,383		334,383		191
191.01	CONTRACT MNGMT & JOINT VENTURE			10,165,208		10,165,208		191.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,355,460	55,370	85,764,701	-2,410,830	83,353,871		202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	A&G NON INTERN & NON RESIDENT	
		0	1	2	2A	4	5.01	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department			1,171	1,171	1,171		4
5.01	A&G NON INTERN & NON RESIDENT	2,223,480	47,157	82,436	2,353,073	71	2,353,144	5.01
5.02	A&G PURCHASING & RECEIVING	3,642		830	4,472	4		5.02
5.03	A&G ADMITTING	175	38,431	2,699	41,305	18		5.03
5.04	A&G PFS CASHIER/ACCTS RECEIVABLE							5.04
5.05	A&G OTHER INTERN & RESIDENT RELATED	13,326	53,649	8,255	75,230	66		5.05
6	Maintenance & Repairs							6
7	Operation of Plant	745,627	264,583	160,503	1,170,713	10		7
8	Laundry & Linen Service							8
9	Housekeeping	4,486	26,969	101,868	133,323	21		9
10	Dietary	33,630	111,959	22,509	168,098	20		10
11	Cafeteria					12		11
12	Maintenance of Personnel							12
13	Nursing Administration			40	40	6		13
14	Central Services & Supply	1,363	121,186		122,549	8		14
15	Pharmacy							15
16	Medical Records & Library	1,046			1,046	9		16
17	Social Service					23		17
18	OTHER GENERAL SERVICE (SPECIFY)	170	13,927		14,097	2		18
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd					32		21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	24,001	1,779,500	124,707	1,928,208	302	901,215	30
44	Skilled Nursing Facility	2,201	300,510		302,711	62	372,167	44
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic			28,134	28,134	29	8,352	54
60	Laboratory					4	82,378	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,465		2,341	5,806	6	47,077	65
66	Physical Therapy	11,291	149,465	8,381	169,137	66	271,096	66
67	Occupational Therapy	1,014	130,934	404	132,352	52	262,886	67
68	Speech Pathology		39,760	49,415	89,175	36	169,594	68
71	Medical Supplies Charged to Patients	94,602			94,602		48,039	71
73	Drugs Charged to Patients	415	56,692	32,438	89,545	31	179,368	73
74	Renal Dialysis						10,972	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	WHEATON OUTPATIENT	4,043		61,558	65,601	61		90.01
90.02	OTHER DAY HOSPITAL	834		31,407	32,241	51		90.02
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	3,168,811	3,134,722	719,096	7,022,629	1,002	2,353,144	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		10,229		10,229			190
191	Research	36		147,745	147,781	2		191
191.01	CONTRACT MNGMT & JOINT VENTURE	7,933		12,608	20,541	167		191.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	3,176,780	3,144,951	879,449	7,201,180	1,171	2,353,144	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	A&G PURCHASING & RECEIVING	A&G ADMITTING	A&G OTHER INTERN & RESIDENT RE	OPERATION OF PLANT	HOUSE-KEEPING	DIETARY	
		5.02	5.03	5.05	7	9	10	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	A&G NON INTERN & NON RESIDENT							5.01
5.02	A&G PURCHASING & RECEIVING	4,476						5.02
5.03	A&G ADMITTING		41,323					5.03
5.04	A&G PFS CASHIER/ACCTS RECEIVABLE							5.04
5.05	A&G OTHER INTERN & RESIDENT RELATED	49		75,345				5.05
6	Maintenance & Repairs							6
7	Operation of Plant	30		4,152	1,174,905			7
8	Laundry & Linen Service							8
9	Housekeeping	2		1,996	11,559	146,901		9
10	Dietary	18		2,162	47,988	6,060	224,346	10
11	Cafeteria			510				11
12	Maintenance of Personnel							12
13	Nursing Administration			311				13
14	Central Services & Supply	79		853	51,943	6,559		14
15	Pharmacy							15
16	Medical Records & Library	2		535				16
17	Social Service			1,183				17
18	OTHER GENERAL SERVICE (SPECIFY)			112	5,970	754		18
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	2		2,051				21
22	I&R Services-Other Prgm Costs Apprvd			49				22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,584	13,590	23,097	762,730	96,312	175,477	30
44	Skilled Nursing Facility	236	5,622	4,950	128,805	16,265	48,869	44
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		126	1,618				54
60	Laboratory	37	1,244	869				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	188	711	557				65
66	Physical Therapy	14	4,213	4,513	64,064	8,090		66
67	Occupational Therapy	33	3,971	3,649	56,121	7,087		67
68	Speech Pathology	23	2,590	2,517	17,042	2,152		68
71	Medical Supplies Charged to Patients	263	726	441				71
73	Drugs Charged to Patients	1,768	2,709	3,180	24,299	3,068		73
74	Renal Dialysis		166	379				74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	WHEATON OUTPATIENT	93	3,370	3,640				90.01
90.02	OTHER DAY HOSPITAL	37	2,285	2,870				90.02
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	4,458	41,323	66,194	1,170,521	146,347	224,346	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen			11	4,384	554		190
191	Research	1		293				191
191.01	CONTRACT MNGMT & JOINT VENTURE	17		8,847				191.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	4,476	41,323	75,345	1,174,905	146,901	224,346	202

MARIANJOY REHAB HOSPITAL & CLINIC Provider CCN: 14-3027	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 08/31/2018	Run Date: 01/30/2019 Run Time: 11:30 Version: 2018.04 (06/21/2018)

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE	
		11	13	14	16	17	18	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	A&G NON INTERN & NON RESIDENT							5.01
5.02	A&G PURCHASING & RECEIVING							5.02
5.03	A&G ADMITTING							5.03
5.04	A&G PFS CASHIER/ACCTS RECEIVABLE							5.04
5.05	A&G OTHER INTERN & RESIDENT RELATED							5.05
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria	522						11
12	Maintenance of Personnel							12
13	Nursing Administration	3	360					13
14	Central Services & Supply	8		181,999				14
15	Pharmacy							15
16	Medical Records & Library	7		109	1,708			16
17	Social Service					1,206		17
18	OTHER GENERAL SERVICE (SPECIFY)	1					20,936	18
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	19		100				21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	206	360	69,917	536	1,206	20,936	30
44	Skilled Nursing Facility	38		10,412	238			44
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	1		1	5			54
60	Laboratory			1,631	53			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	4		633	30			65
66	Physical Therapy	39		633	178			66
67	Occupational Therapy	25		1,459	168			67
68	Speech Pathology	16		994	109			68
71	Medical Supplies Charged to Patients			11,616	31			71
73	Drugs Charged to Patients	13		78,012	114			73
74	Renal Dialysis				7			74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	WHEATON OUTPATIENT	30		4,107	142			90.01
90.02	OTHER DAY HOSPITAL	27		1,618	97			90.02
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	437	360	181,242	1,708	1,206	20,936	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
191	Research	1		26				191
191.01	CONTRACT MNGMT & JOINT VENTURE	84		731				191.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	522	360	181,999	1,708	1,206	20,936	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	I&R SALARY & FRINGES	I&R PROGRAM COSTS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		21	22	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	A&G NON INTERN & NON RESIDENT							5.01
5.02	A&G PURCHASING & RECEIVING							5.02
5.03	A&G ADMITTING							5.03
5.04	A&G PFS CASHIER/ACCTS RECEIVABLE							5.04
5.05	A&G OTHER INTERN & RESIDENT RELATED							5.05
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
18	OTHER GENERAL SERVICE (SPECIFY)							18
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	2,204						21
22	I&R Services-Other Prgm Costs Apprvd		49					22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics			3,995,676		3,995,676		30
44	Skilled Nursing Facility			890,375		890,375		44
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic			38,266		38,266		54
60	Laboratory			86,216		86,216		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			55,012		55,012		65
66	Physical Therapy			522,043		522,043		66
67	Occupational Therapy			467,803		467,803		67
68	Speech Pathology			284,248		284,248		68
71	Medical Supplies Charged to Patients			155,718		155,718		71
73	Drugs Charged to Patients			382,107		382,107		73
74	Renal Dialysis			11,524		11,524		74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	WHEATON OUTPATIENT			77,044		77,044		90.01
90.02	OTHER DAY HOSPITAL			39,226		39,226		90.02
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)			7,005,258		7,005,258		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen			15,178		15,178		190
191	Research			148,104		148,104		191
191.01	CONTRACT MNGMT & JOINT VENTURE			30,387		30,387		191.01
200	Cross Foot Adjustments	2,204	49	2,253		2,253		200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,204	49	7,201,180		7,201,180		202

MARIANJOY REHAB HOSPITAL & CLINIC Provider CCN: 14-3027	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 08/31/2018	Run Date: 01/30/2019 Run Time: 11:30 Version: 2018.04 (06/21/2018)

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	A&G NON IN TERN & NON RESIDENT INPATIENT REVENUE	A&G PURCHA SING & REC EIVING ALLOCATION	A&G ADMITT ING GROSS REVENUE	
		1	2	4	5.01	5.02	5.03	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	163,260						1
2	Cap Rel Costs-Mvble Equip		569,972					2
4	Employee Benefits Department		759	43,907,033				4
5.01	A&G NON INTERN & NON RESIDENT	2,448	53,427	2,636,102	100,124,452			5.01
5.02	A&G PURCHASING & RECEIVING		538	163,030		1,671,491		5.02
5.03	A&G ADMITTING	1,995	1,749	671,632		21	116,466,672	5.03
5.04	A&G PFS CASHIER/ACCTS RECEIVABLE							5.04
5.05	A&G OTHER INTERN & RESIDENT RELATED	2,785	5,350	2,457,470		18,404		5.05
6	Maintenance & Repairs							6
7	Operation of Plant	13,735	104,021	384,644		11,101		7
8	Laundry & Linen Service							8
9	Housekeeping	1,400	66,021	790,155		877		9
10	Dietary	5,812	14,588	741,642		6,734		10
11	Cafeteria			431,718				11
12	Maintenance of Personnel							12
13	Nursing Administration		26	210,315		55		13
14	Central Services & Supply	6,291		289,270		29,438		14
15	Pharmacy							15
16	Medical Records & Library			324,474		926		16
17	Social Service			847,298				17
18	OTHER GENERAL SERVICE (SPECIFY)	723		62,858				18
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd			1,174,717		847		21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	92,377	80,823	11,680,729	38,345,494	591,591	38,345,494	30
44	Skilled Nursing Facility	15,600		2,314,312	15,835,566	88,100	15,835,566	44
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		18,234	1,060,505	355,381	5	355,381	54
60	Laboratory			151,196	3,505,153	13,803	3,505,153	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		1,517	224,194	2,003,090	70,270	2,003,090	65
66	Physical Therapy	7,759	5,432	2,450,239	11,535,021	5,354	11,869,005	66
67	Occupational Therapy	6,797	262	1,908,631	11,185,674	12,341	11,185,674	67
68	Speech Pathology	2,064	32,026	1,350,891	7,216,135	8,409	7,295,308	68
71	Medical Supplies Charged to Patients				2,044,059	98,284	2,044,059	71
73	Drugs Charged to Patients	2,943	21,023	1,154,092	7,632,019	660,077	7,632,019	73
74	Renal Dialysis				466,860		466,860	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	WHEATON OUTPATIENT		39,896	2,263,251		34,753	9,493,611	90.01
90.02	OTHER DAY HOSPITAL		20,355	1,893,127		13,687	6,435,452	90.02
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	162,729	466,047	37,636,492	100,124,452	1,665,077	116,466,672	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	531						190
191	Research		95,754	83,704		224		191
191.01	CONTRACT MNGMT & JOINT VENTURE		8,171	6,186,837		6,190		191.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	3,144,951	879,449	2,186,150	6,138,523	334,650	958,818	202
203	Unit Cost Multiplier (Wkst. B, Part I)	19.263451	1.542969	0.049790	0.061309	0.200210	0.008233	203
204	Cost to be allocated (Per Wkst. B, Part II)			1,171	2,353,144	4,476	41,323	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000027	0.023502	0.002678	0.000355	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	A&G PFS CASHIER/ACCTS RECEIVAB INPATIENT REVENUE	RECON-CILIATION	A&G OTHER INTERN & RESIDENT RE ACCUM COST	MAIN-TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	HOUSE-KEEPING SQUARE FEET	
		5.04	5A.05	5.05	6	7	9	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	A&G NON INTERN & NON RESIDENT							5.01
5.02	A&G PURCHASING & RECEIVING							5.02
5.03	A&G ADMITTING							5.03
5.04	A&G PFS CASHIER/ACCTS RECEIVABLE	100,124,452						5.04
5.05	A&G OTHER INTERN & RESIDENT RELATED		-15,450,216	70,314,485				5.05
6	Maintenance & Repairs				156,032			6
7	Operation of Plant			3,873,576	13,735	142,297		7
8	Laundry & Linen Service							8
9	Housekeeping			1,861,707	1,400	1,400	140,897	9
10	Dietary			2,017,138	5,812	5,812	5,812	10
11	Cafeteria			475,687				11
12	Maintenance of Personnel							12
13	Nursing Administration			290,526				13
14	Central Services & Supply			796,057	6,291	6,291	6,291	14
15	Pharmacy							15
16	Medical Records & Library			498,955				16
17	Social Service			1,103,682				17
18	OTHER GENERAL SERVICE (SPECIFY)			104,693	723	723	723	18
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd			1,913,497				21
22	I&R Services-Other Prgm Costs Apprvd			45,395				22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	38,345,494		21,573,010	92,377	92,377	92,377	30
44	Skilled Nursing Facility	15,835,566		4,617,931	15,600	15,600	15,600	44
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	355,381		1,508,939				54
60	Laboratory	3,505,153		810,807				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,003,090		519,987				65
66	Physical Therapy	11,535,021		4,209,687	7,759	7,759	7,759	66
67	Occupational Therapy	11,185,674		3,403,959	6,797	6,797	6,797	67
68	Speech Pathology	7,216,135		2,347,596	2,064	2,064	2,064	68
71	Medical Supplies Charged to Patients	2,044,059		411,619				71
73	Drugs Charged to Patients	7,632,019		2,966,341	2,943	2,943	2,943	73
74	Renal Dialysis	466,860		353,999				74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	WHEATON OUTPATIENT			3,395,940				90.01
90.02	OTHER DAY HOSPITAL			2,677,413				90.02
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	100,124,452	-15,450,216	61,778,141	155,501	141,766	140,366	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen			10,229	531	531	531	190
191	Research			273,046				191
191.01	CONTRACT MNGMT & JOINT VENTURE			8,253,069				191.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)			15,450,216		4,724,717	2,317,264	202
203	Unit Cost Multiplier (Wkst. B, Part I)			0.219730		33.203209	16.446511	203
204	Cost to be allocated (Per Wkst. B, Part II)			75,345		1,174,905	146,901	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.001072		8.256710	1.042613	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

MARIANJOY REHAB HOSPITAL & CLINIC Provider CCN: 14-3027	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 08/31/2018	Run Date: 01/30/2019 Run Time: 11:30 Version: 2018.04 (06/21/2018)

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	DIETARY PATIENT DAYS	CAFETERIA MEALS SERVED	NURSING ADMINIS-TRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY ALLOCATION 2	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT	
		10	11	13	14	16	17	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	A&G NON INTERN & NON RESIDENT							5.01
5.02	A&G PURCHASING & RECEIVING							5.02
5.03	A&G ADMITTING							5.03
5.04	A&G PFS CASHIER/ACCTS RECEIVABLE							5.04
5.05	A&G OTHER INTERN & RESIDENT RELATED							5.05
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary	43,080						10
11	Cafeteria		1,004,994					11
12	Maintenance of Personnel							12
13	Nursing Administration		5,408	1,000				13
14	Central Services & Supply		15,683		1,539,944			14
15	Pharmacy							15
16	Medical Records & Library		12,730		926	116,466,672		16
17	Social Service						1,000	17
18	OTHER GENERAL SERVICE (SPECIFY)		2,475					18
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		36,026		847			21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	33,696	395,949	1,000	591,591	38,345,494	1,000	30
44	Skilled Nursing Facility	9,384	73,840		88,100	15,835,566		44
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		2,600		5	355,381		54
60	Laboratory				13,803	3,505,153		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		7,010		5,354	2,003,090		65
66	Physical Therapy		75,525		5,354	11,869,005		66
67	Occupational Therapy		48,547		12,341	11,185,674		67
68	Speech Pathology		31,408		8,409	7,295,308		68
71	Medical Supplies Charged to Patients				98,284	2,044,059		71
73	Drugs Charged to Patients		24,086		660,077	7,632,019		73
74	Renal Dialysis					466,860		74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	WHEATON OUTPATIENT		58,198		34,753	9,493,611		90.01
90.02	OTHER DAY HOSPITAL		51,563		13,687	6,435,452		90.02
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	43,080	841,048	1,000	1,533,531	116,466,672	1,000	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
191	Research		1,997		224			191
191.01	CONTRACT MNGMT & JOINT VENTURE		161,949		6,189			191.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,748,928	580,210	357,485	1,292,375	616,716	1,346,194	202
203	Unit Cost Multiplier (Wkst. B, Part I)	63.809842	0.577327	357.485000	0.839235	0.005295	1,346.194000	203
204	Cost to be allocated (Per Wkst. B, Part II)	224,346	522	360	181,999	1,708	1,206	204
205	Unit Cost Multiplier (Wkst. B, Part II)	5.207660	0.000519	0.360000	0.118185	0.000015	1.206000	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

MARIANJOY REHAB HOSPITAL & CLINIC Provider CCN: 14-3027	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 08/31/2018	Run Date: 01/30/2019 Run Time: 11:30 Version: 2018.04 (06/21/2018)

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME				
		18	21	22				
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	A&G NON INTERN & NON RESIDENT							5.01
5.02	A&G PURCHASING & RECEIVING							5.02
5.03	A&G ADMITTING							5.03
5.04	A&G PFS CASHIER/ACCTS RECEIVABLE							5.04
5.05	A&G OTHER INTERN & RESIDENT RELATED							5.05
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
18	OTHER GENERAL SERVICE (SPECIFY)	1,000						18
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		1,000					21
22	I&R Services-Other Prgm Costs Apprvd			1,000				22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,000	1,000	1,000				30
44	Skilled Nursing Facility							44
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic							54
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	WHEATON OUTPATIENT							90.01
90.02	OTHER DAY HOSPITAL							90.02
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,000	1,000	1,000				118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
191	Research							191
191.01	CONTRACT MNGMT & JOINT VENTURE							191.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	165,023	2,355,460	55,370				202
203	Unit Cost Multiplier (Wkst. B, Part I)	165.023000	2,355.460000	55.370000				203
204	Cost to be allocated (Per Wkst. B, Part II)	20,936	2,204	49				204
205	Unit Cost Multiplier (Wkst. B, Part II)	20.936000	2.204000	0.049000				205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

MARIANJOY REHAB HOSPITAL & CLINIC Provider CCN: 14-3027	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 08/31/2018	Run Date: 01/30/2019 Run Time: 11:30 Version: 2018.04 (06/21/2018)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	CODE	LINE NO.	AMOUNT	
	1	2	3	4	

MARIANJOY REHAB HOSPITAL & CLINIC Provider CCN: 14-3027	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 08/31/2018	Run Date: 01/30/2019 Run Time: 11:30 Version: 2018.04 (06/21/2018)

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	35,846,731		35,846,731	154,518	36,001,249	30
44	Skilled Nursing Facility	7,206,373		7,206,373		7,206,373	44
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	1,843,885		1,843,885		1,843,885	54
60	Laboratory	1,019,110		1,019,110		1,019,110	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	653,390		653,390		653,390	65
66	Physical Therapy	5,630,856		5,630,856		5,630,856	66
67	Occupational Therapy	4,586,992		4,586,992		4,586,992	67
68	Speech Pathology	3,029,729		3,029,729		3,029,729	68
71	Medical Supplies Charged to Patients	595,370		595,370		595,370	71
73	Drugs Charged to Patients	4,372,531		4,372,531		4,372,531	73
74	Renal Dialysis	434,255		434,255		434,255	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	WHEATON OUTPATIENT	4,255,164		4,255,164		4,255,164	90.01
90.02	OTHER DAY HOSPITAL	3,341,053		3,341,053		3,341,053	90.02
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)	72,815,439		72,815,439	154,518	72,969,957	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	72,815,439		72,815,439		72,969,957	202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	38,345,494		38,345,494				30
44	Skilled Nursing Facility	15,835,566		15,835,566				44
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	355,381		355,381	5.188474	5.188474	5.188474	54
60	Laboratory	3,505,153		3,505,153	0.290746	0.290746	0.290746	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,003,090		2,003,090	0.326191	0.326191	0.326191	65
66	Physical Therapy	11,535,021	333,984	11,869,005	0.474417	0.474417	0.474417	66
67	Occupational Therapy	11,185,674		11,185,674	0.410077	0.410077	0.410077	67
68	Speech Pathology	7,216,135	79,173	7,295,308	0.415298	0.415298	0.415298	68
71	Medical Supplies Charged to Patients	2,044,059		2,044,059	0.291269	0.291269	0.291269	71
73	Drugs Charged to Patients	7,632,019		7,632,019	0.572919	0.572919	0.572919	73
74	Renal Dialysis	466,860		466,860	0.930161	0.930161	0.930161	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	WHEATON OUTPATIENT		9,493,611	9,493,611	0.448213	0.448213	0.448213	90.01
90.02	OTHER DAY HOSPITAL		6,435,452	6,435,452	0.519164	0.519164	0.519164	90.02
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	100,124,452	16,342,220	116,466,672				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	100,124,452	16,342,220	116,466,672				202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check Applicable Boxes:
[ ] Title V
[XX] Title XVIII, Part A
[ ] Title XIX
[XX] PPS
[ ] TEFRA

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	3,995,676		3,995,676	33,696	118.58	16,800	1,992,144	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility	890,375		890,375	9,384	94.88	5,755	546,034	44
45	Nursing Facility								45
200	Total (lines 30-199)	4,886,051		4,886,051	43,080		22,555	2,538,178	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-3027** **WORKSHEET D PART II**

Check Applicable Boxes: **[ ] Title V** **[XX] Title XVIII, Part A** **[ ] Title XIX** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[XX] PPS** **[ ] TEFRA**

		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 (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	38,266	355,381	0.107676	208,621	22,463	54
60	Laboratory	86,216	3,505,153	0.024597	1,837,674	45,201	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	55,012	2,003,090	0.027464	1,061,080	29,142	65
66	Physical Therapy	522,043	11,869,005	0.043984	5,805,946	255,369	66
67	Occupational Therapy	467,803	11,185,674	0.041822	5,685,574	237,782	67
68	Speech Pathology	284,248	7,295,308	0.038963	3,703,049	144,282	68
71	Medical Supplies Charged to Pat	155,718	2,044,059	0.076181	1,015,222	77,341	71
73	Drugs Charged to Patients	382,107	7,632,019	0.050066	3,571,338	178,803	73
74	Renal Dialysis	11,524	466,860	0.024684	256,545	6,333	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	WHEATON OUTPATIENT	77,044	9,493,611	0.008115			90.01
90.02	OTHER DAY HOSPITAL	39,226	6,435,452	0.006095			90.02
92	Observation Beds (Non-Distinct						92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,119,207	62,285,612		23,145,049	996,716	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS **WORKSHEET D PART III**

Check Applicable Boxes: **[ ] Title V** **[XX] Title XVIII, Part A** **[ ] Title XIX** **[XX] PPS** **[ ] TEFRA** **[ ] Other**

		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust-ment Amount (see instruct-ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1A	1	2A	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)								30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	TOTAL (lines 30-199)								200

(A) Worksheet A line numbers

MARIANJOY REHAB HOSPITAL & CLINIC Provider CCN: 14-3027	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 08/31/2018	Run Date: 01/30/2019 Run Time: 11:30 Version: 2018.04 (06/21/2018)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V [XX] PPS
[XX] Title XVIII, Part A [ ] TEFRA
[ ] Title XIX [ ] Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	33,696		16,800		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility	9,384		5,755		44
45	Nursing Facility					45
200	Total (lines 30-199)	43,080		22,555		200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-3027** | **WORKSHEET D PART IV**

Check Applicable Boxes: [ ] Title V | [XX] Title XVIII, Part A | [ ] Title XIX | [XX] Hospital | [ ] IPF | [ ] IRF | [ ] SUB (Other) | [ ] SNF | [ ] NF | [ ] ICF/IID | [XX] PPS | [ ] TEFRA | [ ] Other

		Non Physician Anesth-etist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
54	Radiology-Diagnostic									54
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
71	Medical Supplies Charged to Pat									71
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
90.01	WHEATON OUTPATIENT									90.01
90.02	OTHER DAY HOSPITAL									90.02
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-3027** | **WORKSHEET D PART IV**

Check Applicable Boxes: [ ] Title V; [XX] Title XVIII, Part A; [ ] Title XIX; [XX] Hospital; [ ] IPF; [ ] IRF; [ ] SUB (Other); [ ] SNF; [ ] NF; [ ] ICF/IID; [XX] PPS; [ ] TEFRA; [ ] Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	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)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	355,381			208,621				54
60	Laboratory	3,505,153			1,837,674				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	2,003,090			1,061,080				65
66	Physical Therapy	11,869,005			5,805,946		92		66
67	Occupational Therapy	11,185,674			5,685,574				67
68	Speech Pathology	7,295,308			3,703,049		1,019		68
71	Medical Supplies Charged to Pat	2,044,059			1,015,222				71
73	Drugs Charged to Patients	7,632,019			3,571,338				73
74	Renal Dialysis	466,860			256,545				74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	WHEATON OUTPATIENT	9,493,611					16,974		90.01
90.02	OTHER DAY HOSPITAL	6,435,452					10,569		90.02
92	Observation Beds (Non-Distinct								92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	62,285,612			23,145,049		28,654		200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-3027** **WORKSHEET D PART V**

Check Applicable Boxes: **[ ] Title V - O/P** **[XX] Title XVIII, Part B** **[ ] Title XIX - O/P** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] NF** **[ ] Swing Bed SNF** **[ ] Swing Bed NF** **[ ] ICF/IID**

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	5.188474							54
60	Laboratory	0.290746							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.326191							65
66	Physical Therapy	0.474417	92			44			66
67	Occupational Therapy	0.410077							67
68	Speech Pathology	0.415298	1,019			423			68
71	Medical Supplies Charged to Pat	0.291269							71
73	Drugs Charged to Patients	0.572919							73
74	Renal Dialysis	0.930161							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	WHEATON OUTPATIENT	0.448213	16,974			7,608			90.01
90.02	OTHER DAY HOSPITAL	0.519164	10,569			5,487			90.02
92	Observation Beds (Non-Distinct								92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		28,654			13,562			200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		28,654			13,562			202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-6129** | **WORKSHEET D PART IV**

Check Applicable Boxes:
[ ] Title V [ ] Hospital [ ] SUB (Other] [ ] ICF/IID [XX] PPS
[XX] Title XVIII, Part A [ ] IPF [XX] SNF [ ] TEFRA
[ ] Title XIX [ ] IRF [ ] NF [ ] Other

		Non Physician Anesth-etist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
54	Radiology-Diagnostic									54
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
71	Medical Supplies Charged to Pat									71
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
90.01	WHEATON OUTPATIENT									90.01
90.02	OTHER DAY HOSPITAL									90.02
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

MARIANJOY REHAB HOSPITAL & CLINIC Provider CCN: 14-3027	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 08/31/2018	Run Date: 01/30/2019 Run Time: 11:30 Version: 2018.04 (06/21/2018)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-6129** **WORKSHEET D PART IV**

Check Applicable Boxes:
[ ] Title V [ ] Hospital [ ] SUB (Other) [ ] ICF/IID [XX] PPS
[XX] Title XVIII, Part A [ ] IPF [XX] SNF [ ] TEFRA
[ ] Title XIX [ ] IRF [ ] NF [ ] Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	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)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	355,381			24,015				54
60	Laboratory	3,505,153			357,126				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	2,003,090			246,263				65
66	Physical Therapy	11,869,005			1,980,638				66
67	Occupational Therapy	11,185,674			1,806,139				67
68	Speech Pathology	7,295,308			206,967				68
71	Medical Supplies Charged to Pat	2,044,059			112,763				71
73	Drugs Charged to Patients	7,632,019			1,007,225				73
74	Renal Dialysis	466,860							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	WHEATON OUTPATIENT	9,493,611							90.01
90.02	OTHER DAY HOSPITAL	6,435,452							90.02
92	Observation Beds (Non-Distinct								92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	62,285,612			5,741,136				200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-6129** **WORKSHEET D PART V**

Check Applicable Boxes:
[ ] Title V - O/P [ ] Hospital [ ] SUB (Other] [ ] Swing Bed SNF
[XX] Title XVIII, Part B [ ] IPF [XX] SNF [ ] Swing Bed NF
[ ] Title XIX - O/P [ ] IRF [ ] NF [ ] ICF/IID

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	5.188474							54
60	Laboratory	0.290746							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.326191							65
66	Physical Therapy	0.474417							66
67	Occupational Therapy	0.410077							67
68	Speech Pathology	0.415298							68
71	Medical Supplies Charged to Pat	0.291269							71
73	Drugs Charged to Patients	0.572919							73
74	Renal Dialysis	0.930161							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	WHEATON OUTPATIENT	0.448213							90.01
90.02	OTHER DAY HOSPITAL	0.519164							90.02
92	Observation Beds (Non-Distinct								92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

MARIANJOY REHAB HOSPITAL & CLINIC Provider CCN: 14-3027	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 08/31/2018	Run Date: 01/30/2019 Run Time: 11:30 Version: 2018.04 (06/21/2018)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check Applicable Boxes:
[ ] Title V [XX] PPS
[ ] Title XVIII, Part A [ ] TEFRA
[XX] Title XIX

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	3,995,676		3,995,676	33,696	118.58	1,662	197,080	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility	890,375		890,375	9,384	94.88	28	2,657	44
45	Nursing Facility								45
200	Total (lines 30-199)	4,886,051		4,886,051	43,080		1,690	199,737	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-3027** **WORKSHEET D PART II**

Check Applicable Boxes: **[ ] Title V** **[ ] Title XVIII, Part A** **[XX] Title XIX** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[XX] PPS** **[ ] TEFRA**

		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 (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	38,266	355,381	0.107676			54
60	Laboratory	86,216	3,505,153	0.024597			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	55,012	2,003,090	0.027464			65
66	Physical Therapy	522,043	11,869,005	0.043984			66
67	Occupational Therapy	467,803	11,185,674	0.041822			67
68	Speech Pathology	284,248	7,295,308	0.038963			68
71	Medical Supplies Charged to Pat	155,718	2,044,059	0.076181			71
73	Drugs Charged to Patients	382,107	7,632,019	0.050066			73
74	Renal Dialysis	11,524	466,860	0.024684			74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	WHEATON OUTPATIENT	77,044	9,493,611	0.008115			90.01
90.02	OTHER DAY HOSPITAL	39,226	6,435,452	0.006095			90.02
92	Observation Beds (Non-Distinct						92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,119,207	62,285,612				200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS **WORKSHEET D PART III**

Check Applicable Boxes: **[ ] Title V** **[XX] Title XVIII, Part A** **[XX] Title XIX** **[XX] PPS** **[ ] TEFRA** **[ ] Other**

		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust-ment Amount (see instruct-ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1A	1	2A	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)								30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	TOTAL (lines 30-199)								200

(A) Worksheet A line numbers

MARIANJOY REHAB HOSPITAL & CLINIC Provider CCN: 14-3027	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 08/31/2018	Run Date: 01/30/2019 Run Time: 11:30 Version: 2018.04 (06/21/2018)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V [XX] PPS
[ ] Title XVIII, Part A [ ] TEFRA
[XX] Title XIX [ ] Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	33,696		1,662		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility	9,384		28		44
45	Nursing Facility					45
200	Total (lines 30-199)	43,080		1,690		200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-3027** | **WORKSHEET D PART IV**

Check Applicable Boxes:
[ ] Title V **[XX] Title XVIII, Part A** **[XX] Title XIX**
[XX] Hospital **[ ] IPF** **[ ] IRF**
[ ] SUB (Other) **[ ] SNF** **[ ] NF**
[ ] ICF/IID
[XX] PPS **[ ] TEFRA** **[ ] Other**

		Non Physician Anesth-etist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
54	Radiology-Diagnostic									54
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
71	Medical Supplies Charged to Pat									71
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
90.01	WHEATON OUTPATIENT									90.01
90.02	OTHER DAY HOSPITAL									90.02
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-3027** | **WORKSHEET D PART IV**

Check Applicable Boxes: [ ] Title V [XX] Title XVIII, Part A [XX] Title XIX | [XX] Hospital [ ] IPF [ ] IRF | [ ] SUB (Other) [ ] SNF [ ] NF | [ ] ICF/IID | [XX] PPS [ ] TEFRA [ ] Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	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)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	355,381							54
60	Laboratory	3,505,153							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	2,003,090							65
66	Physical Therapy	11,869,005							66
67	Occupational Therapy	11,185,674							67
68	Speech Pathology	7,295,308							68
71	Medical Supplies Charged to Pat	2,044,059							71
73	Drugs Charged to Patients	7,632,019							73
74	Renal Dialysis	466,860							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	WHEATON OUTPATIENT	9,493,611							90.01
90.02	OTHER DAY HOSPITAL	6,435,452							90.02
92	Observation Beds (Non-Distinct								92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	62,285,612							200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-3027** **WORKSHEET D PART V**

Check Applicable Boxes: **[ ] Title V - O/P** **[XX] Title XIX - O/P** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] NF** **[ ] Swing Bed SNF** **[ ] Swing Bed NF** **[ ] ICF/IID**

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	5.188474							54
60	Laboratory	0.290746							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.326191							65
66	Physical Therapy	0.474417							66
67	Occupational Therapy	0.410077							67
68	Speech Pathology	0.415298							68
71	Medical Supplies Charged to Pat	0.291269							71
73	Drugs Charged to Patients	0.572919							73
74	Renal Dialysis	0.930161							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	WHEATON OUTPATIENT	0.448213							90.01
90.02	OTHER DAY HOSPITAL	0.519164							90.02
92	Observation Beds (Non-Distinct								92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-3027** **WORKSHEET D-1 PART I**

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[XX] PPS**
	[XX] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
	[ ] Title XIX - I/P	**[ ] IRF**	**[ ] NF**		**[ ] Other**

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	33,696	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	33,696	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	33,696	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	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)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	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)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	16,800	9
10	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)		10
11	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)		11
12	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		12
13	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)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	36,001,249	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	36,001,249	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	36,001,249	37

MARIANJOY REHAB HOSPITAL & CLINIC Provider CCN: 14-3027	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 08/31/2018	Run Date: 01/30/2019 Run Time: 11:30 Version: 2018.04 (06/21/2018)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-3027** **WORKSHEET D-1 PART II**

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[XX] PPS**
	[XX] Title XVIII, Part A	**[ ] IPF**		**[ ] TEFRA**
	[ ] Title XIX - I/P	**[ ] IRF**		**[ ] Other**

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					1,068.41	38
39	Program general inpatient routine service cost (line 9 x line 38)					17,949,288	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)					17,949,288	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					11,167,085	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					29,116,373	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,992,144	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					996,716	51
52	Total Program excludable cost (sum of lines 50 and 51)					2,988,860	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					26,127,513	53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	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 (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

Check Applicable Boxes: [ ] Title V - I/P [XX] Title XVIII, Part A [ ] Title XIX - I/P | [XX] Hospital [ ] IPF [ ] IRF | [ ] SUB (Other) [ ] SNF [ ] NF | [ ] ICF/IID | [XX] PPS [ ] TEFRA [ ] Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)						87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,068.41	88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

MARIANJOY REHAB HOSPITAL & CLINIC Provider CCN: 14-3027	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 08/31/2018	Run Date: 01/30/2019 Run Time: 11:30 Version: 2018.04 (06/21/2018)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-6129** **WORKSHEET D-1 PART I**

Check	**[ ] Title V - I/P**	**[ ] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[XX] PPS**
Applicable	**[XX] Title XVIII, Part A**	**[ ] IPF**	**[XX] SNF**		**[ ] TEFRA**
Boxes:	**[ ] Title XIX - I/P**	**[ ] IRF**	**[ ] NF**		**[ ] Other**

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	9,384	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,384	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	9,384	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	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)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	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)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	5,755	9
10	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)		10
11	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)		11
12	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		12
13	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)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	7,206,373	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,206,373	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	7,206,373	37

MARIANJOY REHAB HOSPITAL & CLINIC Provider CCN: 14-3027	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 08/31/2018	Run Date: 01/30/2019 Run Time: 11:30 Version: 2018.04 (06/21/2018)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-6129** **WORKSHEET D-1**
PARTS III & IV

Check	**[ ] Title V - I/P**	**[ ] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[XX] PPS**
Applicable	**[XX] Title XVIII, Part A**	**[ ] IPF**	**[XX] SNF**		**[ ] TEFRA**
Boxes:	**[ ] Title XIX - I/P**	**[ ] IRF**	**[ ] NF**		**[ ] Other**

PART III - SNF, NF, AND ICF/IID ONLY

70	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	7,206,373	70
71	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	767.94	71
72	Program routine service cost (line 9 x line 71)	4,419,495	72
73	Medically necessary private room cost applicable to Program (line 14 x line 35)		73
74	Total Program general inpatient routine service costs (line 72 + line 73)	4,419,495	74
75	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26)		75
76	Per diem capital-related costs (line 75 ÷ line 2)		76
77	Program capital-related costs (line 9 x line 76)		77
78	Inpatient routine service cost (line 74 minus line 77)		78
79	Aggregate charges to beneficiaries for excess costs (from provider records)		79
80	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80
81	Inpatient routine service cost per diem limitation		81
82	Inpatient routine service cost limitation (line 9 x line 81)		82
83	Reasonable inpatient routine service costs (see instructions)	4,419,495	83
84	Program inpatient ancillary services (see instructions)	2,684,922	84
85	Utilization review - physician compensation (see instructions)		85
86	Total Program inpatient operating costs (sum of lines 83 through 85)	7,104,417	86

MARIANJOY REHAB HOSPITAL & CLINIC Provider CCN: 14-3027	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 08/31/2018	Run Date: 01/30/2019 Run Time: 11:30 Version: 2018.04 (06/21/2018)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-3027** **WORKSHEET D-1 PART I**

Check	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[XX] PPS**
Applicable	**[ ] Title XVIII, Part A**	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
Boxes:	**[XX] Title XIX - I/P**	**[ ] IRF**	**[ ] NF**		**[ ] Other**

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	33,696	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	33,696	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	33,696	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	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)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	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)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,662	9
10	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)		10
11	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)		11
12	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		12
13	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)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	36,001,249	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	36,001,249	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	36,001,249	37

MARIANJOY REHAB HOSPITAL & CLINIC Provider CCN: 14-3027	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 08/31/2018	Run Date: 01/30/2019 Run Time: 11:30 Version: 2018.04 (06/21/2018)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-3027** **WORKSHEET D-1 PART II**

Check Applicable Boxes: [ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [XX] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] TEFRA
[XX] Title XIX - I/P [ ] IRF [ ] Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					1,068.41	38
39	Program general inpatient routine service cost (line 9 x line 38)					1,775,697	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)					1,775,697	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					1,775,697	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					197,080	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51
52	Total Program excludable cost (sum of lines 50 and 51)					197,080	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					1,578,617	53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	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 (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

Check	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[XX] PPS**
Applicable	**[ ] Title XVIII, Part A**	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
Boxes:	**[XX] Title XIX - I/P**	**[ ] IRF**	**[ ] NF**		**[ ] Other**

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)						87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,068.41	88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

MARIANJOY REHAB HOSPITAL & CLINIC Provider CCN: 14-3027	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 08/31/2018	Run Date: 01/30/2019 Run Time: 11:30 Version: 2018.04 (06/21/2018)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-3027** **WORKSHEET D-3**

Check Applicable Boxes:	**[ ] Title V**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[XX] PPS**
	[XX] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
	[ ] Title XIX	**[ ] IRF**	**[ ] NF**	**[ ] ICF/IID**	**[ ] Other**

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		18,914,647		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	5.188474	208,621	1,082,425	54
60	Laboratory	0.290746	1,837,674	534,296	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.326191	1,061,080	346,115	65
66	Physical Therapy	0.474417	5,805,946	2,754,439	66
67	Occupational Therapy	0.410077	5,685,574	2,331,523	67
68	Speech Pathology	0.415298	3,703,049	1,537,869	68
71	Medical Supplies Charged to Patients	0.291269	1,015,222	295,703	71
73	Drugs Charged to Patients	0.572919	3,571,338	2,046,087	73
74	Renal Dialysis	0.930161	256,545	238,628	74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	WHEATON OUTPATIENT	0.448213			90.01
90.02	OTHER DAY HOSPITAL	0.519164			90.02
92	Observation Beds (Non-Distinct Part)				92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		23,145,049	11,167,085	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		23,145,049		202

(A) Worksheet A line numbers

MARIANJOY REHAB HOSPITAL & CLINIC Provider CCN: 14-3027	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 08/31/2018	Run Date: 01/30/2019 Run Time: 11:30 Version: 2018.04 (06/21/2018)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-6129** **WORKSHEET D-3**

Check Applicable Boxes:	**[ ] Title V**	**[ ] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[XX] PPS**
	[XX] Title XVIII, Part A	**[ ] IPF**	**[XX] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
	[ ] Title XIX	**[ ] IRF**	**[ ] NF**	**[ ] ICF/IID**	**[ ] Other**

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	5.188474	24,015	124,601	54
60	Laboratory	0.290746	357,126	103,833	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.326191	246,263	80,329	65
66	Physical Therapy	0.474417	1,980,638	939,648	66
67	Occupational Therapy	0.410077	1,806,139	740,656	67
68	Speech Pathology	0.415298	206,967	85,953	68
71	Medical Supplies Charged to Patients	0.291269	112,763	32,844	71
73	Drugs Charged to Patients	0.572919	1,007,225	577,058	73
74	Renal Dialysis	0.930161			74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	WHEATON OUTPATIENT	0.448213			90.01
90.02	OTHER DAY HOSPITAL	0.519164			90.02
92	Observation Beds (Non-Distinct Part)				92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		5,741,136	2,684,922	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		5,741,136		202

(A) Worksheet A line numbers

MARIANJOY REHAB HOSPITAL & CLINIC Provider CCN: 14-3027	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 08/31/2018	Run Date: 01/30/2019 Run Time: 11:30 Version: 2018.04 (06/21/2018)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-3027** **WORKSHEET D-3**

Check Applicable Boxes:	**[ ] Title V**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[XX] PPS**
	[ ] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
	[XX] Title XIX	**[ ] IRF**	**[ ] NF**	**[ ] ICF/IID**	**[ ] Other**

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	5.188474			54
60	Laboratory	0.290746			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.326191			65
66	Physical Therapy	0.474417			66
67	Occupational Therapy	0.410077			67
68	Speech Pathology	0.415298			68
71	Medical Supplies Charged to Patients	0.291269			71
73	Drugs Charged to Patients	0.572919			73
74	Renal Dialysis	0.930161			74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	WHEATON OUTPATIENT	0.448213			90.01
90.02	OTHER DAY HOSPITAL	0.519164			90.02
92	Observation Beds (Non-Distinct Part)				92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)	13,562			2
3	OPPS payments	7,686			3
4	Outlier payment (see instructions)	3,023			4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)	0.943			5
6	Line 2 times line 5	12,789			6
7	Sum of lines 3, 4, and 4.01, divided by line 6	0.8374			7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	10,709			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	933			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	9,776			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)	325			28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	10,101			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	10,101			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)	22			34
35	Adjusted reimbursable bad debts (see instructions)	14			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	22			36
37	Subtotal (see instructions)	10,115			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	10,115			40
40.01	Sequestration adjustment (see instructions)	202			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	9,642			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	271			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (sse instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

MARIANJOY REHAB HOSPITAL & CLINIC Provider CCN: 14-3027	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 08/31/2018	Run Date: 01/30/2019 Run Time: 11:30 Version: 2018.04 (06/21/2018)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-6129** **WORKSHEET E PART B**

Check applicable box: [ ] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [XX] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	OPPS payments				3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)				27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)				30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)				37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)				40
40.01	Sequestration adjustment (see instructions)				40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (sse instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

MARIANJOY REHAB HOSPITAL & CLINIC Provider CCN: 14-3027	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 08/31/2018	Run Date: 01/30/2019 Run Time: 11:30 Version: 2018.04 (06/21/2018)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-3027** **WORKSHEET E-1 PART I**

Check Applicable Boxes: **[XX] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [ ] SNF [ ] Swing Bed SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				29,381,721		9,642	1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01	05/24/2018	2,184,155			3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		2,184,155			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				31,565,876		9,642	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01				271	6.01
	based on the cost report (1)		.02		-2,514,427			6.02
7	Total Medicare program liability (see instructions)				29,051,449		9,913	7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

MARIANJOY REHAB HOSPITAL & CLINIC Provider CCN: 14-3027	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 08/31/2018	Run Date: 01/30/2019 Run Time: 11:30 Version: 2018.04 (06/21/2018)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-6129** **WORKSHEET E-1 PART I**

Check Applicable Boxes: **[ ] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [XX] SNF [ ] Swing Bed SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				2,954,357			1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				2,954,357			4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01					6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				2,954,357			7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

Check Applicable Box: **[XX] Hospital** **[ ] Subprovider IRF**

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1.01	
1	Net Federal PPS payment (see instructions)	24,252,653		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.005200		2
3	Inpatient Rehabilitation LIP payments (see instructions)	540,834		3
4	Outlier payments	348,070		4
5	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	12.75		5
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) OR (2)			5.01
6	New teaching program adjustment (see instructions)			6
7	Current year unweighted FTE count of I&R excludnig FTEs in the new program growth period of a 'new teaching program' (see instructions)	13.85		7
8	Current year unweighted I&R FTE count for residents within the new program growth period of a 'new teaching program' (see instructions)			8
9	Intern and resident count for IRF PPS medical education adjustment (see instructions)	12.75		9
10	Average daily census (see instructions)	78.913349		10
11	Teaching Adjustment Factor (see instructions)	0.164409		11
12	Teaching Adjustment (see instructions)	3,987,354		12
13	Total PPS Payment (see instructions)	29,128,911		13
14	Nursing and allied health managed care payments (see instructions)			14
15	Organ acquisition DO NOT USE THIS LINE			15
16	Cost of physicians' services in a teaching hospital (see instructions)			16
17	Subtotal (see instructions)	29,128,911		17
18	Primary payer payments	62,213		18
19	Subtotal (line 17 less line 18)	29,066,698		19
20	Deductibles	179,796		20
21	Subtotal (line 19 minus line 20)	28,886,902		21
22	Coinsurance	181,152		22
23	Subtotal (line 21 minus line 22)	28,705,750		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)	97,854		24
25	Adjusted reimbursable bad debts (see instructions)	63,605		25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)	34,099		26
27	Subtotal (sum of lines 23 and 25)	28,769,355		27
28	Direct graduate medical education payments (from Wkst. E-4, line 49) (For free standing IRF only)	874,981		28
29	Other pass through costs (see instructions)			29
30	Outlier payments reconciliation			30
31	Other adjustments (OTHER ADJUSTMENTS (SEE INSTRUCTIONS))			31
31.01	MSP PASS THROUGH			31.01
31.02	MSP LLC ADJUSTMENT			31.02
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			31.50
32	Total amount payable to the provider (see instructions)	29,644,336		32
32.01	Sequestration adjustment (see instructions)	592,887		32.01
32.02	Demonstration payment adjustment amount after sequestration			32.02
33	Interim payments	31,565,876		33
34	Tentative settlement (for contractor use only)			34
35	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33 and 34)	-2,514,427		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	786,676		36

TO BE COMPLETED BY CONTRACTOR

50	Original outlier amount from Wkst. E-3, Pt. III, line 4 (see instructions)			50
51	Outlier reconciliation adjustment amount (see instructions)			51
52	The rate used to calculate the Time Value of Money (see instructions)			52
53	Time Value of Money (see instructions)			53

MARIANJOY REHAB HOSPITAL & CLINIC Provider CCN: 14-3027	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 08/31/2018	Run Date: 01/30/2019 Run Time: 11:30 Version: 2018.04 (06/21/2018)

CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E-3**
PART VI

PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES

	PROSPECTIVE PAYMENT AMOUNT (see instructions)		
1	Resource Utilization Group (RUGS) payment	3,082,961	1
2	Routine service other pass through costs		2
3	Ancillary service other pass through costs		3
4	Subtotal (sum of lines 1-3)	3,082,961	4
	COMPUTATION OF NET COST OF COVERED SERVICES		
5	Medical and other services. Do not use this line. (see instructions)		5
6	Deductibles		6
7	Coinsurance	68,311	7
8	Allowable bad debts (see instructions)		8
9	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		9
10	Adjusted reimbursable bad debts (see instructions)		10
11	Utilization review		11
12	Subtotal (sum of lines 4 and 5, minus lines 6 and 7, plus lines 10 and 11) (see instructions)	3,014,650	12
13	Inpatient primary payer payments		13
14	Other adjustments (specify) (see instructions)		14
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		14.50
15	Subtotal (see instructions)	3,014,650	15
15.01	Sequestration adjustment (see instructions)	60,293	15.01
15.02	Demonstration payment adjustment amount after sequestration		15.02
16	Interim payments	2,954,357	16
17	Tentative settlement (for contractor use only)		17
18	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16 and 17)		18
19	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		19

MARIANJOY REHAB HOSPITAL & CLINIC Provider CCN: 14-3027	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 08/31/2018	Run Date: 01/30/2019 Run Time: 11:30 Version: 2018.04 (06/21/2018)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-3027** **WORKSHEET E-3 PART VII**

Check Applicable Boxes: **[ ] Title V** **[XX] Title XIX** **[XX] Hospital** **[ ] SUB (Other)** **[ ] SNF** **[ ] NF** **[ ] ICF/IID** **[XX] PPS** **[ ] TEFRA** **[ ] Other**

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services			1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)			4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)			38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS **WORKSHEET E-4**

Check Applicable Box: **[ ] Title V [XX] Title XVIII [ ] Title XIX**

	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996			16.19	1
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)				2
3	Amount of reduction to Direct GME cap under §422 of MMA			1.28	3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)				3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and §413.79(f))				4
4.01	ACA §5503 increase to the direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011)				4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)				4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)			14.91	5
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			13.85	6
7	Enter the lesser of line 5 or line 6			13.85	7
		Primary Care	Other	Total	
		1	2	3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	0.00	13.85	13.85	8
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	0.00	13.85	13.85	9
10	Weighted dental and podiatric resident FTE count for the current year		0.00		10
10.01	Unweighted dental and podiatric resident FTE count for the current year		12.43		10.01
11	Total weighted FTE count	0.00	13.85		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	14.91		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	12.43		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.00	13.73		14
15	Adjustment for residents in initial years of new programs	0.00	0.00		15
15.01	Unweighted adjustment for residents in initial years of new programs				15.01
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16
16.01	Unweighted adjustment for residents displaced by program or hospital closure				16.01
17	Adjusted rolling average FTE count	0.00	13.73		17
18	Per resident amount	113,520.67	107,790.50		18
19	Approved amount for resident costs		1,479,964	1,479,964	19
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)				20
21	Direct GME FTE unweighted resident count over cap (see instructions)				21
22	Allowable additional direct GME FTE resident count (see instructions)				22
23	Enter the locality adjustment national average per resident amount (see instructions)				23
24	Multiply line 22 times line 23				24
25	Total direct GME amount (sum of lines 19 and 24)			1,479,964	25
	COMPUTATION OF PROGRAM PATIENT LOAD	Inpatient Part A	Managed Care		
26	Inpatient days (see instructions)	16,800	3,644		26
27	Total inpatient days (see instructions)	33,696	33,696		27
28	Ratio of inpatient days to total inpatient days	0.498575	0.108143		28
29	Program direct GME amount	737,873	160,048		29
30	Reduction for direct GME payments for Medicare Advantage		22,615		30
31	Net Program direct GME amount			875,306	31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)				32
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			466,860	33
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)				34
35	Medicare outpatient ESRD charges (see instructions)				35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)				36
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
	Part A Reasonable Cost				
37	Reasonable cost (see instructions)			36,618,829	37
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)				38
39	Cost of physicians' services in a teaching hospital (see instructions)				39
40	Primary payer payments (see instructions)			62,213	40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			36,556,616	41
	Part B Reasonable Cost				
42	Reasonable cost (see instructions)			13,562	42
43	Primary payer payments (see instructions)				43
44	Total Part B reasonable cost (line 42 minus line 43)			13,562	44
45	Total reasonable cost (sum of lines 41 and 44)			36,570,178	45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.999629	46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.000371	47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	Total program GME payment (line 31)			875,306	48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			874,981	49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			325	50

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS **WORKSHEET E-4**

Check Applicable Box:
[ ] Title V
[ ] Title XVIII
[XX] Title XIX

	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996				1
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)				2
3	Amount of reduction to Direct GME cap under §422 of MMA				3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)				3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and §413.79(f))				4
4.01	ACA §5503 increase to the direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011)				4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)				4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)				5
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)				6
7	Enter the lesser of line 5 or line 6				7
		Primary Care	Other	Total	
		1	2	3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	0.00	0.00	0.00	8
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	0.00	0.00	0.00	9
10	Weighted dental and podiatric resident FTE count for the current year		0.00		10
10.01	Unweighted dental and podiatric resident FTE count for the current year				10.01
11	Total weighted FTE count	0.00	0.00		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.00	0.00		14
15	Adjustment for residents in initial years of new programs	0.00	0.00		15
15.01	Unweighted adjustment for residents in initial years of new programs				15.01
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16
16.01	Unweighted adjustment for residents displaced by program or hospital closure				16.01
17	Adjusted rolling average FTE count	0.00	0.00		17
18	Per resident amount	0.00	0.00		18
19	Approved amount for resident costs				19
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)				20
21	Direct GME FTE unweighted resident count over cap (see instructions)				21
22	Allowable additional direct GME FTE resident count (see instructions)				22
23	Enter the locality adjustment national average per resident amount (see instructions)				23
24	Multiply line 22 times line 23				24
25	Total direct GME amount (sum of lines 19 and 24)				25
	COMPUTATION OF PROGRAM PATIENT LOAD	Inpatient Part A	Managed Care		
26	Inpatient days (see instructions)	1,662	588		26
27	Total inpatient days (see instructions)	33,696	33,696		27
28	Ratio of inpatient days to total inpatient days	0.049323	0.017450		28
29	Program direct GME amount				29
30	Reduction for direct GME payments for Medicare Advantage				30
31	Net Program direct GME amount				31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)				32
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)				33
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)				34
35	Medicare outpatient ESRD charges (see instructions)				35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)				36
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
	Part A Reasonable Cost				
37	Reasonable cost (see instructions)				37
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)				38
39	Cost of physicians' services in a teaching hospital (see instructions)				39
40	Primary payer payments (see instructions)				40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)				41
	Part B Reasonable Cost				
42	Reasonable cost (see instructions)				42
43	Primary payer payments (see instructions)				43
44	Total Part B reasonable cost (line 42 minus line 43)				44
45	Total reasonable cost (sum of lines 41 and 44)				45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)				46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)				47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	Total program GME payment (line 31)				48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)				49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)				50

MARIANJOY REHAB HOSPITAL & CLINIC Provider CCN: 14-3027	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 08/31/2018	Run Date: 01/30/2019 Run Time: 11:30 Version: 2018.04 (06/21/2018)

BALANCE SHEET **WORKSHEET G**

(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	21,471,000				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	10,378,000				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable					6
7	Inventory					7
8	Prepaid expenses	212,000				8
9	Other current assets					9
10	Due from other funds	2,491,000				10
11	Total current assets (sum of lines 1-10)	34,552,000				11
	FIXED ASSETS					
12	Land	6,800,000				12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	62,868,000				15
16	Accumulated depreciation	-10,088,000				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	6,442,000				19
20	Accumulated depreciation					20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment					23
24	Accumulated depreciation					24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	66,022,000				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	2,597,000				34
35	Total other assets (sum of lines 31-34)	2,597,000				35
36	Total assets (sum of lines 11, 30 and 35)	103,171,000				36

	Liabilities and Fund Balances	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	541,000				37
38	Salaries, wages and fees payable	3,112,000				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	13,583,000				44
45	Total current liabilities (sum of lines 37 thru 44)	17,236,000				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities					49
50	Total long term liabilities (sum of lines 46 thru 49)					50
51	Total liabilities (sum of lines 45 and 50)	17,236,000				51
	CAPITAL ACCOUNTS					
52	General fund balance	85,935,000				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	85,935,000				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	103,171,000				60

STATEMENT OF CHANGES IN FUND BALANCES **WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		84,788,000			1
2	Net income (loss) (from Worksheet G-3, line 29)		1,147,000			2
3	Total (sum of line 1 and line 2)		85,935,000			3
4	Additions (credit adjustments) (specify)					4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)		85,935,000			11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		85,935,000			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)					11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)					19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	38,345,494		38,345,494	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility	15,835,566		15,835,566	7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	54,181,060		54,181,060	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit				11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)				16
17	Total inpatient routine care services (sum of lines 10 and 16)	54,181,060		54,181,060	17
18	Ancillary services	45,947,779		45,947,779	18
19	Outpatient services		20,224,291	20,224,291	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	100,128,839	20,224,291	120,353,130	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		88,898,556	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		88,898,556	43

MARIANJOY REHAB HOSPITAL & CLINIC Provider CCN: 14-3027	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 08/31/2018	Run Date: 01/30/2019 Run Time: 11:30 Version: 2018.04 (06/21/2018)

STATEMENT OF REVENUES AND EXPENSES **WORKSHEET G-3**

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	120,353,130	1
2	Less contractual allowances and discounts on patients' accounts	46,580,130	2
3	Net patient revenues (line 1 minus line 2)	73,773,000	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	88,898,556	4
5	Net income from service to patients (line 3 minus line 4)	-15,125,556	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments		7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests		14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (OTHER INCOME)	8,100,326	24
25	Total other income (sum of lines 6-24)	8,100,326	25
26	Total (line 5 plus line 25)	-7,025,230	26
27	Other expenses (OTHER CONTRIBUTIONS)	-8,172,230	27
28	Total other expenses (sum of line 27 and subscripts)	-8,172,230	28
29	Net income (or loss) for the period (line 26 minus line 28)	1,147,000	29