

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050 EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-4031	Period: From 07/01/2017 To 06/30/2018	Worksheet S Parts I-III Date/Time Prepared: 11/28/2018 11:47 am
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PART I - COST REPORT STATUS

Provider use only 1. Electronically filed cost report Date: 11/28/2018 Time: 11:47 am
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

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

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 ALEXIAN BROTHERS BEHAVIORAL HEALTH (14-4031) for the cost reporting period beginning 07/01/2017 and ending 06/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) DAVID JONES
 Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER
 Title

(Dated when report is electronically signed.)
 Date

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-77,026	13,823	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0	0	0		0	6.00
200.00 Total	0	-77,026	13,823	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-4031		Period: From 07/01/2017 To 06/30/2018		Worksheet S-2 Part I Date/Time Prepared: 11/28/2018 11:36 am				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 1650 MOON LAKE BOULEVARD			PO Box:							1.00	
2.00	City: HOFFMAN ESTATES			State: IL		Zip Code: 60194-		County: COOK			2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
				1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:												
3.00	Hospital			ALEXIAN BROTHERS BEHAVIORAL HEALTH	144031	16974	4	06/28/1990	N	P	O	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF											7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:		To:			
							1.00		2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2017		06/30/2018		20.00	
21.00	Type of Control (see instructions)						1				21.00	
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (PickLe amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N		N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						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		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						0		N		23.00	
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days			
				1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	0	0	0	0	0		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.			0	0	0	0	0	0		25.00	

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		Urban/Rural	S	Date of Geogr		
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.		1			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.		1			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.		0			35.00
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.		0			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)		N			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)		N		N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)		N		N	40.00
		V	XVIII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)		N		N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.		N		N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.		N		N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.		N		N	48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.		N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.		N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.		N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.		N			59.00
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
		1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)		Y			60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)			23.00	1	60.01
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N		0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)					61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)					61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)					61.03

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	Y/N	IME	Direct GME	IME	Direct GME			
	1.00	2.00	3.00	4.00	5.00			
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04	
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05	
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06	
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
	1.00		2.00	3.00	4.00			
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						61.10	0.00 0.00
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						61.20	0.00 0.00
							1.00	
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>								
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)						62.00	0.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)						62.01	0.00
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>								
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)						63.00	N
	Program Name		Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
	1.00		2.00	3.00	4.00	5.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64.00	0.00 0.00 0.000000

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
					1.00	2.00	3.00
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			Y			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N		0	71.00
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	76.00

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			1.00				
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N	80.00			
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N	81.00			
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N	85.00			
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00			
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87.00			
			V 1.00	XIX 2.00			
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00		
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N	91.00		
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00		
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00		
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00		
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00		
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00		
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00		
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.00		
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.01		
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.02		
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.03		
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.04		
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.05		
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.06		
Rural Providers							
105.00	Does this hospital qualify as a CAH?		N		105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00		
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.				107.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00		
			Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N	N	N	109.00
			1.00				
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N		110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-4031	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/28/2018 11:36 am		
		1.00	2.00			
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00
		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	1	0			118.01
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N				121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		149019		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-4031	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/28/2018 11:36 am
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	1.00	2.00	3.00				
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: ALEXIAN BROTHERS HOSPITAL NETWORK	Contractor's Name: WPS	Contractor's Number: 05001	141.00			
142.00	Street: 2601 NAVI STAR DRIVE	PO Box:		142.00			
143.00	City: LISLE	State: IL	Zip Code: 60532	143.00			
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?			144.00			
				Y			
				1.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145.00			
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.			146.00			
				N			
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			147.00			
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			148.00			
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			149.00			
				N			
				N			
				N			
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N		
156.00	Subprovider - IPF	N	N	N	N		
157.00	Subprovider - IRF	N	N	N	N		
158.00	SUBPROVIDER						
159.00	SNF	N	N	N	N		
160.00	HOME HEALTH AGENCY	N	N	N	N		
161.00	CMHC	N	N	N	N		
				1.00			
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			165.00			
				N			
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						166.00
							0.00
							1.00
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)						168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						169.00
						0.00	
						1.00	
						2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)						170.00
						1.00	
						2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						171.00
						N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-4031		Period: From 07/01/2017 To 06/30/2018		Worksheet S-2 Part II Date/Time Prepared: 11/28/2018 11:36 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N			14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N			15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	10/18/2018	Y	10/18/2018		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-4031	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/28/2018 11:36 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N	06/30/2018	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00		2.00	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ROSS		STEBBINS	41.00
42.00	Enter the employer/company name of the cost report preparer.	AMITA HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	630-312-7270		ROSS.STEBBINS@AMITAHEALTH.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-4031	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/28/2018 11:36 am
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER OF REIMBURSEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-4031

Period:
From 07/01/2017
To 06/30/2018

Worksheet S-3
Part I
Date/Time Prepared:
11/28/2018 11:36 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	141	51,465	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		141	51,465	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		141	51,465	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		141				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-4031

Period:
From 07/01/2017
To 06/30/2018

Worksheet S-3
Part I
Date/Time Prepared:
11/28/2018 11:36 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	12,921	897	45,139			1.00
2.00 HMO and other (see instructions)	433	2,277				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	12,921	897	45,139			7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	12,921	897	45,139	0.00	620.83	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	620.83	27.00
28.00 Observation Bed Days		0	0			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00
33.01 LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-4031

Period:
From 07/01/2017
To 06/30/2018

Worksheet S-3
Part I
Date/Time Prepared:
11/28/2018 11:36 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	855	126	5,538	1.00
2.00 HMO and other (see instructions)				34	0		2.00
3.00 HMO IPF Subprovider					0		3.00
4.00 HMO IRF Subprovider					0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0	855	126	5,538		14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00						26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days				0			33.00
33.01 LTCH site neutral days and discharges				0			33.01

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 14-4031		Period: From 07/01/2017 To 06/30/2018		Worksheet S-3 Part II Date/Time Prepared: 11/28/2018 11:36 am	
	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	41,480,698	0	41,480,698	1,291,323.00	32.12	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		12,494,292	596,685	13,090,977	219,870.00	59.54	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract Labor: Direct Patient Care		0	0	0	0.00	0.00	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract Labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		6,144,246	0	6,144,246			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		2,833,215	0	2,833,215			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	188,338	0	188,338	1.00	188,338.00	26.00
27.00	Administrative & General	5.00	8,076,844	-112,500	7,964,344	288,075.00	27.65	27.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-4031

Period:
From 07/01/2017
To 06/30/2018

Worksheet S-3
Part II
Date/Time Prepared:
11/28/2018 11:36 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	139,832	0	139,832	40,982.00	3.41	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	314,107	-52,012	262,095	51,470.00	5.09	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	52,012	52,012	6,727.00	7.73	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,321,060	0	1,321,060	35,272.00	37.45	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	416,399	0	416,399	19,335.00	21.54	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-4031

Period:
From 07/01/2017
To 06/30/2018

Worksheet S-3
Part III
Date/Time Prepared:
11/28/2018 11:36 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	41,480,698	0	41,480,698	1,291,323.00	32.12	1.00
2.00	Excluded area salaries (see instructions)	12,494,292	596,685	13,090,977	219,870.00	59.54	2.00
3.00	Subtotal salaries (line 1 minus line 2)	28,986,406	-596,685	28,389,721	1,071,453.00	26.50	3.00
4.00	Subtotal other wages & related costs (see inst.)	0	0	0	0.00	0.00	4.00
5.00	Subtotal wage-related costs (see inst.)	6,144,246	0	6,144,246	0.00	21.64	5.00
6.00	Total (sum of lines 3 thru 5)	35,130,652	-596,685	34,533,967	1,071,453.00	32.23	6.00
7.00	Total overhead cost (see instructions)	10,456,580	-112,500	10,344,080	441,862.00	23.41	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-4031	Period: From 07/01/2017 To 06/30/2018	Worksheet S-3 Part IV Date/Time Prepared: 11/28/2018 11:36 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		0	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		0	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		0	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		0	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		0	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COST		0	25.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-4031

Period:
From 07/01/2017
To 06/30/2018

Worksheet A

Date/Time Prepared:
11/28/2018 11:36 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		865,633	865,633	1,063,352	1,928,985	1.00
2.00	00200		195,898	195,898	0	195,898	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	188,338	6,077,746	6,266,084	0	6,266,084	4.00
5.00	00500	8,076,844	26,063,484	34,140,328	-1,764,626	32,375,702	5.00
6.00	00600	0	0	0	0	0	6.00
7.00	00700	0	703,725	703,725	0	703,725	7.00
8.00	00800	0	0	0	56,556	56,556	8.00
9.00	00900	139,832	928,339	1,068,171	-56,556	1,011,615	9.00
10.00	01000	314,107	1,933,261	2,247,368	-276,525	1,970,843	10.00
11.00	01100	0	0	0	276,525	276,525	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	1,321,060	258,616	1,579,676	-574	1,579,102	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	416,399	517,010	933,409	0	933,409	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	663,181	663,181	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	14,745,173	3,280,327	18,025,500	-193,373	17,832,127	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	343	33,538	33,881	190	34,071	54.00
60.00	06000	0	171,768	171,768	37,672	209,440	60.00
66.00	06600	166,752	11,802	178,554	2,113	180,667	66.00
69.00	06900	0	0	0	0	0	69.00
73.00	07300	0	1,612,387	1,612,387	36,858	1,649,245	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03320	503,177	119,386	622,563	18,904	641,467	76.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200						92.00
93.00	04950	3,114,381	424,847	3,539,228	136,070	3,675,298	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		0	0	0	0	113.00
118.00		28,986,406	43,197,767	72,184,173	-233	72,183,940	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100	0	0	0	69	69	191.00
192.00	19200	11,324,853	1,382,684	12,707,537	0	12,707,537	192.00
194.00	07950	28,054	2,183	30,237	164	30,401	194.00
194.01	07951	605,750	44,494	650,244	0	650,244	194.01
194.02	07952	535,635	37,107	572,742	0	572,742	194.02
200.00		41,480,698	44,664,235	86,144,933	0	86,144,933	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-4031

Period:
From 07/01/2017
To 06/30/2018

Worksheet A
Date/Time Prepared:
11/28/2018 11:36 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-243,019	1,685,966	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-659,799	-463,901	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,266,084	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,592,478	34,968,180	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-8,270	695,455	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	56,556	8.00
9.00	00900	HOUSEKEEPING	0	1,011,615	9.00
10.00	01000	DIETARY	0	1,970,843	10.00
11.00	01100	CAFETERIA	-204,704	71,821	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,579,102	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-397	933,012	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	663,181	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	17,832,127	30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	34,071	54.00
60.00	06000	LABORATORY	0	209,440	60.00
66.00	06600	PHYSICAL THERAPY	0	180,667	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,649,245	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03320	ELECTROSHOCK THERAPY	0	641,467	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIpsy	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.00	04950	PARTIAL HOSPITALIZATION	0	3,675,298	93.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0	0	94.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,476,289	73,660,229	118.00
NONREIMBURSABLE COST CENTERS					
191.00	19100	RESEARCH	0	69	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-5,824,457	6,883,080	192.00
194.00	07950	DUI PROGRAM	0	30,401	194.00
194.01	07951	I PPS	0	650,244	194.01
194.02	07952	RESIDENTIAL CENTER	0	572,742	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-4,348,168	81,796,765	200.00

RECLASSIFICATIONS

Provider CCN: 14-4031

Period:
From 07/01/2017
To 06/30/2018

Worksheet A-6

Date/Time Prepared:
11/28/2018 11:36 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - RENTAL EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	13,128	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	13,128	
B - BUILDING RENTAL					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	237,128	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	237,128	
C - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	52,012	224,513	1.00
	TOTALS		52,012	224,513	
D - PFS RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	0	357,362	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	190	2.00
3.00	LABORATORY	60.00	0	37,672	3.00
4.00	PHYSICAL THERAPY	66.00	0	2,113	4.00
5.00	DRUGS CHARGED TO PATIENTS	73.00	0	36,858	5.00
6.00	ELECTROSHOCK THERAPY	76.00	0	18,904	6.00
7.00	PARTIAL HOSPITALIZATION	93.00	0	203,438	7.00
8.00	RESEARCH	191.00	0	69	8.00
9.00	DUI PROGRAM	194.00	0	164	9.00
	TOTALS		0	656,770	
E - LAUNDRY					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	56,556	1.00
	TOTALS		0	56,556	
F - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	813,096	1.00
	TOTALS		0	813,096	
J - PARAMEDICAL EDUCATION					
1.00	PARAMED ED PRGM-(SPECIFY)	23.00	596,685	66,496	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		596,685	66,496	
500.00	Grand Total: Increases		648,697	2,067,687	500.00

RECLASSIFICATIONS

Provider CCN: 14-4031

Period:
From 07/01/2017
To 06/30/2018

Worksheet A-6

Date/Time Prepared:
11/28/2018 11:36 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - RENTAL EXPENSE							
1.00	ADULTS & PEDIATRICS	30.00	0	12,554	10		1.00
2.00	NURSING ADMINISTRATION	13.00	0	574	0		2.00
	TOTALS		0	13,128			
B - BUILDING RENTAL							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	169,760	10		1.00
2.00	PARTIAL HOSPITALIZATION	93.00	0	67,368	0		2.00
	TOTALS		0	237,128			
C - CAFETERIA RECLASS							
1.00	DIETARY	10.00	52,012	224,513	0		1.00
	TOTALS		52,012	224,513			
D - PFS RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	656,770	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
	TOTALS		0	656,770			
E - LAUNDRY							
1.00	HOUSEKEEPING	9.00	0	56,556	0		1.00
	TOTALS		0	56,556			
F - INTEREST EXPENSE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	813,096	11		1.00
	TOTALS		0	813,096			
J - PARAMEDICAL EDUCATION							
1.00	ADULTS & PEDIATRICS	30.00	371,685	41,496	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	112,500	12,500	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	112,500	12,500	0		3.00
	TOTALS		596,685	66,496			
500.00	Grand Total: Decreases		648,697	2,067,687			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-4031

Period:
From 07/01/2017
To 06/30/2018

Worksheet A-7
Part I
Date/Time Prepared:
11/28/2018 11:36 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,540,000	0	0	0	1.00
2.00	Land Improvements	267,675	0	0	0	2.00
3.00	Buildings and Fixtures	21,305,100	0	0	0	3.00
4.00	Building Improvements	2,189,801	442,194	0	442,194	4.00
5.00	Fixed Equipment	440,615	0	0	0	5.00
6.00	Movable Equipment	2,283,468	271,817	0	271,817	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	28,026,659	714,011	0	714,011	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	28,026,659	714,011	0	714,011	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,540,000	0			1.00
2.00	Land Improvements	267,675	0			2.00
3.00	Buildings and Fixtures	21,305,100	0			3.00
4.00	Building Improvements	2,631,995	0			4.00
5.00	Fixed Equipment	440,615	0			5.00
6.00	Movable Equipment	2,555,285	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	28,740,670	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	28,740,670	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-4031

Period:
From 07/01/2017
To 06/30/2018

Worksheet A-7
Part II
Date/Time Prepared:
11/28/2018 11:36 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	865,633	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	195,898	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,061,531	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	865,633				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	195,898				2.00
3.00	Total (sum of lines 1-2)	0	1,061,531				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-4031

Period:
From 07/01/2017
To 06/30/2018

Worksheet A-7
Part III
Date/Time Prepared:
11/28/2018 11:36 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	26,185,385	0	26,185,385	0.911092	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,555,285	0	2,555,285	0.088908	0	2.00
3.00	Total (sum of lines 1-2)	28,740,670	0	28,740,670	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	622,614	250,256	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	-463,901	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	158,713	250,256	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	813,096	0	0	0	1,685,966	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	-463,901	2.00
3.00	Total (sum of lines 1-2)	813,096	0	0	0	1,222,065	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-4031

Period:
From 07/01/2017
To 06/30/2018

Worksheet A-8

Date/Time Prepared:
11/28/2018 11:36 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00		3.00	4.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00	0	7.00
8.00 Television and radio service (chapter 21)			0		0.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-125,893				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	2,661,067				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-153,890	CAFETERIA		11.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-397	MEDICAL RECORDS & LIBRARY		16.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	A	-17,848	CAP REL COSTS-BLDG & FIXT		1.00	9	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00 MISC INCOME	B	-53,494	ADMINISTRATIVE & GENERAL		5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-4031

Period:
From 07/01/2017
To 06/30/2018

Worksheet A-8

Date/Time Prepared:
11/28/2018 11:36 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
33.03 GROUP PRACTICE HBP	A	-5,824,457	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.03
34.00 BUSINESS DEVELOPMENT/MARKETING	A	-251,431	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00 BUSINESS DEVELOPMENT OTHER INCO	B	-58,710	ADMINISTRATIVE & GENERAL	5.00	0	35.00
37.00 SCHOOL REIMBURSEMENT	A	-463,258	ADMINISTRATIVE & GENERAL	5.00	0	37.00
39.00 REAL ESTATE TAXES	A	-9,043	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.01 VENDING	B	-50,814	CAFETERIA	11.00	0	40.01
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,348,168				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS
 Provider CCN: 14-4031
 Period: From 07/01/2017 To 06/30/2018
 Worksheet A-8-1
 Date/Time Prepared: 11/28/2018 11:36 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	0	813,096 1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL RELATED BUILDING	0	225,171 2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	CAPITAL RELATED EQUIPMENT	0	659,799 3.00
3.02	5.00	ADMINISTRATIVE & GENERAL	ADMIN AND GENERAL	14,817,096	10,449,693 3.02
3.03	7.00	OPERATION OF PLANT	OPERATION OF PLANT	0	8,270 3.03
3.04	0.00			0	0 3.04
3.06	0.00			0	0 3.06
3.07	0.00			0	0 3.07
3.11	0.00			0	0 3.11
4.00	0.00			0	0 4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			14,817,096	12,156,029 5.00

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

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

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

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

6.00	B	ABHN	100.00	0.00	6.00
7.00			0.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or non-financial) specify:			0.00	100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 14-4031

Period:
From 07/01/2017
To 06/30/2018

Worksheet A-8-1

Date/Time Prepared:
11/28/2018 11:36 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-813,096	0		1.00
2.00	-225,171	9		2.00
3.00	-659,799	9		3.00
3.02	4,367,403	0		3.02
3.03	-8,270	0		3.03
3.04	0	0		3.04
3.06	0	0		3.06
3.07	0	0		3.07
3.11	0	0		3.11
4.00	0	0		4.00
5.00	2,661,067			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-4031

Period:
From 07/01/2017
To 06/30/2018

Worksheet A-8-2

Date/Time Prepared:
11/28/2018 11:36 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	DR. A	325,893	0	325,893	200,000	2,080	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			325,893	0	325,893		2,080	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	DR. A	200,000	10,000	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			200,000	10,000	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	DR. A	0	200,000	125,893	125,893		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	200,000	125,893	125,893		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-4031

Period:
From 07/01/2017
To 06/30/2018

Worksheet B
Part I
Date/Time Prepared:
11/28/2018 11:36 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,685,966	1,685,966			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	-463,901		-463,901		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	6,266,084	0	0	6,266,084	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	34,968,180	519,448	0	1,208,581	36,696,209
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	695,455	7,909	0	0	703,364
8.00 00800	LAUNDRY & LINEN SERVICE	56,556	3,510	0	0	60,066
9.00 00900	HOUSEKEEPING	1,011,615	1,974	0	21,219	1,034,808
10.00 01000	DIETARY	1,970,843	22,149	0	39,773	2,032,765
11.00 01100	CAFETERIA	71,821	35,807	0	7,893	115,521
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	1,579,102	0	0	200,470	1,779,572
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	0	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	933,012	14,121	0	63,188	1,010,321
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	663,181	6,120	0	90,546	759,847
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	17,832,127	784,737	0	2,164,101	20,780,965
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	34,071	0	0	52	34,123
60.00 06000	LABORATORY	209,440	0	0	0	209,440
66.00 06600	PHYSICAL THERAPY	180,667	0	0	25,304	205,971
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,649,245	6,027	0	0	1,655,272
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00 03320	ELECTROSHOCK THERAPY	641,467	8,160	0	76,357	725,984
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99 07699	LITHOTRIpsy	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.00 04950	PARTIAL HOSPITALIZATION	3,675,298	73,495	0	472,604	4,221,397
OTHER REIMBURSABLE COST CENTERS						
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	73,660,229	1,483,457	0	4,370,088	72,025,625
NONREIMBURSABLE COST CENTERS						
191.00 19100	RESEARCH	69	2,729	0	0	2,798
192.00 19200	PHYSICIANS' PRIVATE OFFICES	6,883,080	199,780	0	1,718,535	8,801,395
194.00 07950	DUI PROGRAM	30,401	0	0	4,257	34,658
194.01 07951	IPPS	650,244	0	0	91,922	742,166
194.02 07952	RESIDENTIAL CENTER	572,742	0	0	81,282	654,024
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers			-463,901	0	-463,901
202.00	TOTAL (sum lines 118 through 201)	81,796,765	1,685,966	-463,901	6,266,084	81,796,765

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 14-4031	Period: From 07/01/2017 To 06/30/2018	Worksheet B Part I Date/Time Prepared: 11/28/2018 11:36 am		
Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING
			5.00	6.00	7.00	8.00	9.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	36,696,209				5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0			6.00
7.00	00700	OPERATION OF PLANT	566,468	0	1,269,832		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	48,375	0	3,847	112,288	8.00
9.00	00900	HOUSEKEEPING	833,402	0	2,163	0	1,870,373
10.00	01000	DIETARY	1,637,126	0	24,275	0	35,926
11.00	01100	CAFETERIA	93,037	0	39,244	0	58,079
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	1,433,212	0	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00	01500	PHARMACY	0	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	813,681	0	15,477	0	22,905
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
23.00	02300	PARAMED ED PRGM-(SPECIFY)	611,957	0	6,708	0	9,927
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	16,736,354	0	860,067	112,288	1,272,844
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,482	0	0	0	0
60.00	06000	LABORATORY	168,676	0	0	0	0
66.00	06600	PHYSICAL THERAPY	165,883	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,333,105	0	6,606	0	9,777
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
76.00	03320	ELECTROSHOCK THERAPY	584,685	0	8,944	0	13,236
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
93.00	04950	PARTIAL HOSPITALIZATION	3,399,782	0	80,551	0	119,209
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,453,225	0	1,047,882	112,288	1,541,903
NONREIMBURSABLE COST CENTERS							
191.00	19100	RESEARCH	2,253	0	2,991	0	4,426
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,088,371	0	218,959	0	324,044
194.00	07950	DUI PROGRAM	27,912	0	0	0	0
194.01	07951	IPPS	597,717	0	0	0	0
194.02	07952	RESIDENTIAL CENTER	526,731	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	36,696,209	0	1,269,832	112,288	1,870,373

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	3,730,092					10.00
11.00	01100		305,881				11.00
12.00	01200			0			12.00
13.00	01300		9,824		3,222,608		13.00
14.00	01400					0	14.00
15.00	01500						15.00
16.00	01600		6,545				16.00
17.00	01700						17.00
19.00	01900						19.00
20.00	02000						20.00
21.00	02100						21.00
22.00	02200						22.00
23.00	02300		3,786				23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	3,730,092	161,944		2,608,884		30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400						54.00
60.00	06000						60.00
66.00	06600		1,330				66.00
69.00	06900						69.00
73.00	07300		5,109				73.00
74.00	07400						74.00
76.00	03320		4,462				76.00
76.97	07697						76.97
76.98	07698						76.98
76.99	07699						76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200						92.00
93.00	04950		38,488		613,724		93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400						94.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		3,730,092	231,488		3,222,608		118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100						191.00
192.00	19200		61,345				192.00
194.00	07950		310				194.00
194.01	07951		12,738				194.01
194.02	07952						194.02
200.00							200.00
201.00							201.00
202.00		3,730,092	305,881		3,222,608		202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL		
		15.00	16.00	17.00	19.00	20.00		
GENERAL SERVICE COST CENTERS								
1.00	00100						1.00	
2.00	00200						2.00	
4.00	00400						4.00	
5.00	00500						5.00	
6.00	00600						6.00	
7.00	00700						7.00	
8.00	00800						8.00	
9.00	00900						9.00	
10.00	01000						10.00	
11.00	01100						11.00	
12.00	01200						12.00	
13.00	01300						13.00	
14.00	01400						14.00	
15.00	01500						15.00	
16.00	01600	0	1,868,929				16.00	
17.00	01700	0	0	0			17.00	
19.00	01900	0	0	0	0		19.00	
20.00	02000	0	0	0		0	20.00	
21.00	02100	0	0	0			21.00	
22.00	02200	0	0	0			22.00	
23.00	02300	0	0	0			23.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	0	1,037,662	0	0	0	30.00	
ANCILLARY SERVICE COST CENTERS								
54.00	05400	0	457	0	0	0	54.00	
60.00	06000	0	101,640	0	0	0	60.00	
66.00	06600	0	7,740	0	0	0	66.00	
69.00	06900	0	0	0	0	0	69.00	
73.00	07300	0	92,655	0	0	0	73.00	
74.00	07400	0	0	0	0	0	74.00	
76.00	03320	0	53,875	0	0	0	76.00	
76.97	07697	0	0	0	0	0	76.97	
76.98	07698	0	0	0	0	0	76.98	
76.99	07699	0	0	0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS								
92.00	09200						92.00	
93.00	04950	0	574,900	0	0	0	93.00	
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	0	0	0	0	0	94.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300						113.00	
118.00	SUBTOTALS (SUM OF LINES 1 through 117)						0	118.00
NONREIMBURSABLE COST CENTERS								
191.00	19100	0	0	0	0	0	191.00	
192.00	19200	0	0	0	0	0	192.00	
194.00	07950	0	0	0	0	0	194.00	
194.01	07951	0	0	0	0	0	194.01	
194.02	07952	0	0	0	0	0	194.02	
200.00	Cross Foot Adjustments						0	200.00
201.00	Negative Cost Centers						0	201.00
202.00	TOTAL (sum lines 118 through 201)						0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description	INTERNS & RESIDENTS		PARAMED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments
	SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV			
	21.00	22.00			
GENERAL SERVICE COST CENTERS					
1.00 00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00 00500	ADMINISTRATIVE & GENERAL				5.00
6.00 00600	MAINTENANCE & REPAIRS				6.00
7.00 00700	OPERATION OF PLANT				7.00
8.00 00800	LAUNDRY & LINEN SERVICE				8.00
9.00 00900	HOUSEKEEPING				9.00
10.00 01000	DIETARY				10.00
11.00 01100	CAFETERIA				11.00
12.00 01200	MAINTENANCE OF PERSONNEL				12.00
13.00 01300	NURSING ADMINISTRATION				13.00
14.00 01400	CENTRAL SERVICES & SUPPLY				14.00
15.00 01500	PHARMACY				15.00
16.00 01600	MEDICAL RECORDS & LIBRARY				16.00
17.00 01700	SOCIAL SERVICE				17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS				19.00
20.00 02000	NURSING SCHOOL				20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0			21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0		22.00
23.00 02300	PARAMED PRGM-(SPECIFY)		1,392,225		23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	0	0	348,056	47,649,156
ANCILLARY SERVICE COST CENTERS					
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	62,062
60.00 06000	LABORATORY	0	0	0	479,756
66.00 06600	PHYSICAL THERAPY	0	0	0	380,924
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,102,524
74.00 07400	RENAL DIALYSIS	0	0	0	0
76.00 03320	ELECTROSHOCK THERAPY	0	0	0	1,391,186
76.97 07697	CARDIAC REHABILITATION	0	0	0	0
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0
76.99 07699	LITHOTRIPSY	0	0	0	0
OUTPATIENT SERVICE COST CENTERS					
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0
93.00 04950	PARTIAL HOSPITALIZATION	0	0	1,044,169	10,092,220
OTHER REIMBURSABLE COST CENTERS					
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0
SPECIAL PURPOSE COST CENTERS					
113.00 11300	INTEREST EXPENSE				113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	0	1,392,225	63,157,828
NONREIMBURSABLE COST CENTERS					
191.00 19100	RESEARCH	0	0	0	12,468
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	16,494,114
194.00 07950	DUI PROGRAM	0	0	0	62,880
194.01 07951	IPPS	0	0	0	1,352,621
194.02 07952	RESIDENTIAL CENTER	0	0	0	1,180,755
200.00	Cross Foot Adjustments	0	0	0	0
201.00	Negative Cost Centers	0	0	0	-463,901
202.00	TOTAL (sum lines 118 through 201)	0	0	1,392,225	81,796,765

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 14-4031	Period: From 07/01/2017 To 06/30/2018	Worksheet B Part I Date/Time Prepared: 11/28/2018 11:36 am
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	47,649,156
ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	62,062
60.00	06000	LABORATORY	479,756
66.00	06600	PHYSICAL THERAPY	380,924
69.00	06900	ELECTROCARDIOLOGY	0
73.00	07300	DRUGS CHARGED TO PATIENTS	3,102,524
74.00	07400	RENAL DIALYSIS	0
76.00	03320	ELECTROSHOCK THERAPY	1,391,186
76.97	07697	CARDIAC REHABILITATION	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0
76.99	07699	LITHOTRIpsy	0
OUTPATIENT SERVICE COST CENTERS			
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	
93.00	04950	PARTIAL HOSPITALIZATION	10,092,220
OTHER REIMBURSABLE COST CENTERS			
94.00	09400	HOME PROGRAM DIALYSIS	0
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	63,157,828
NONREIMBURSABLE COST CENTERS			
191.00	19100	RESEARCH	12,468
192.00	19200	PHYSICIANS' PRIVATE OFFICES	16,494,114
194.00	07950	DUI PROGRAM	62,880
194.01	07951	IPPS	1,352,621
194.02	07952	RESIDENTIAL CENTER	1,180,755
200.00		Cross Foot Adjustments	0
201.00		Negative Cost Centers	-463,901
202.00		TOTAL (sum lines 118 through 201)	81,796,765

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-4031	Period: From 07/01/2017 To 06/30/2018	Worksheet B Part II Date/Time Prepared: 11/28/2018 11:36 am
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	519,448	0	519,448	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	0	7,909	0	7,909	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	3,510	0	3,510	8.00
9.00 00900	HOUSEKEEPING	0	1,974	0	1,974	9.00
10.00 01000	DIETARY	0	22,149	0	22,149	10.00
11.00 01100	CAFETERIA	0	35,807	0	35,807	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	0	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	14,121	0	14,121	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	6,120	0	6,120	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	784,737	0	784,737	30.00
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00 06000	LABORATORY	0	0	0	0	60.00
66.00 06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	6,027	0	6,027	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00 03320	ELECTROSHOCK THERAPY	0	8,160	0	8,160	76.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99 07699	LITHOTRIpsy	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART			0	0	92.00
93.00 04950	PARTIAL HOSPITALIZATION	0	73,495	0	73,495	93.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	1,483,457	0	1,483,457	118.00
NONREIMBURSABLE COST CENTERS						
191.00 19100	RESEARCH	0	2,729	0	2,729	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	199,780	0	199,780	192.00
194.00 07950	DUI PROGRAM	0	0	0	0	194.00
194.01 07951	IPPS	0	0	0	0	194.01
194.02 07952	RESIDENTIAL CENTER	0	0	0	0	194.02
200.00	Cross Foot Adjustments			0	0	200.00
201.00	Negative Cost Centers			-463,901	-463,901	201.00
202.00	TOTAL (sum lines 118 through 201)	0	1,685,966	-463,901	1,222,065	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-4031	Period: From 07/01/2017 To 06/30/2018	Worksheet B Part II Date/Time Prepared: 11/28/2018 11:36 am		
Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING
			5.00	6.00	7.00	8.00	9.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	519,448				5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0			6.00
7.00	00700	OPERATION OF PLANT	8,018	0	15,927		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	685	0	48	4,243	8.00
9.00	00900	HOUSEKEEPING	11,797	0	27	0	13,798
10.00	01000	DIETARY	23,174	0	304	0	265
11.00	01100	CAFETERIA	1,317	0	492	0	428
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	20,287	0	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00	01500	PHARMACY	0	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	11,518	0	194	0	169
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
23.00	02300	PARAMED ED PRGM-(SPECFY)	8,662	0	84	0	73
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	236,915	0	10,789	4,243	9,390
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	389	0	0	0	0
60.00	06000	LABORATORY	2,388	0	0	0	0
66.00	06600	PHYSICAL THERAPY	2,348	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	18,870	0	83	0	72
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
76.00	03320	ELECTROSHOCK THERAPY	8,276	0	112	0	98
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIpsy	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.00	04950	PARTIAL HOSPITALIZATION	48,124	0	1,010	0	879
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	402,768	0	13,143	4,243	11,374
NONREIMBURSABLE COST CENTERS							
191.00	19100	RESEARCH	32	0	38	0	33
192.00	19200	PHYSICIANS' PRIVATE OFFICES	100,336	0	2,746	0	2,391
194.00	07950	DUI PROGRAM	395	0	0	0	0
194.01	07951	IPPS	8,461	0	0	0	0
194.02	07952	RESIDENTIAL CENTER	7,456	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	519,448	0	15,927	4,243	13,798

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-4031		Period: From 07/01/2017 To 06/30/2018		Worksheet B Part II Date/Time Prepared: 11/28/2018 11:36 am	
Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	45,892					10.00
11.00	01100	CAFETERIA	0	38,044				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	1,222	0	21,509		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	814	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	471	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	45,892	20,142	0	17,413	0	30.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0	165	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	635	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03320	ELECTROSHOCK THERAPY	0	555	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	PARTIAL HOSPITALIZATION	0	4,787	0	4,096	0	93.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	45,892	28,791	0	21,509	0	118.00
NONREIMBURSABLE COST CENTERS								
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,630	0	0	0	192.00
194.00	07950	DUI PROGRAM	0	39	0	0	0	194.00
194.01	07951	IPPS	0	1,584	0	0	0	194.01
194.02	07952	RESIDENTIAL CENTER	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	45,892	38,044	0	21,509	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-4031		Period: From 07/01/2017 To 06/30/2018		Worksheet B Part II Date/Time Prepared: 11/28/2018 11:36 am	
Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	0					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	26,816				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	14,873	0			30.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7	0			54.00
60.00	06000	LABORATORY	0	1,460	0			60.00
66.00	06600	PHYSICAL THERAPY	0	111	0			66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0			69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,331	0			73.00
74.00	07400	RENAL DIALYSIS	0	0	0			74.00
76.00	03320	ELECTROSHOCK THERAPY	0	774	0			76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIpsy	0	0	0			76.99
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	PARTIAL HOSPITALIZATION	0	8,260	0			93.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0			94.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	26,816	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
191.00	19100	RESEARCH	0	0	0			191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0			192.00
194.00	07950	DUI PROGRAM	0	0	0			194.00
194.01	07951	IPPS	0	0	0			194.01
194.02	07952	RESIDENTIAL CENTER	0	0	0			194.02
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	26,816	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-4031	Period: From 07/01/2017 To 06/30/2018	Worksheet B Part II Date/Time Prepared: 11/28/2018 11:36 am
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Cost Center Description	INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments
	SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV			
	21.00	22.00			
GENERAL SERVICE COST CENTERS					
1.00 00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00 00500	ADMINISTRATIVE & GENERAL				5.00
6.00 00600	MAINTENANCE & REPAIRS				6.00
7.00 00700	OPERATION OF PLANT				7.00
8.00 00800	LAUNDRY & LINEN SERVICE				8.00
9.00 00900	HOUSEKEEPING				9.00
10.00 01000	DIETARY				10.00
11.00 01100	CAFETERIA				11.00
12.00 01200	MAINTENANCE OF PERSONNEL				12.00
13.00 01300	NURSING ADMINISTRATION				13.00
14.00 01400	CENTRAL SERVICES & SUPPLY				14.00
15.00 01500	PHARMACY				15.00
16.00 01600	MEDICAL RECORDS & LIBRARY				16.00
17.00 01700	SOCIAL SERVICE				17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS				19.00
20.00 02000	NURSING SCHOOL				20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0			21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0		22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)		15,410		23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS			1,144,394	0 30.00
ANCILLARY SERVICE COST CENTERS					
54.00 05400	RADIOLOGY-DIAGNOSTIC			396	0 54.00
60.00 06000	LABORATORY			3,848	0 60.00
66.00 06600	PHYSICAL THERAPY			2,624	0 66.00
69.00 06900	ELECTROCARDIOLOGY			0	0 69.00
73.00 07300	DRUGS CHARGED TO PATIENTS			27,018	0 73.00
74.00 07400	RENAL DIALYSIS			0	0 74.00
76.00 03320	ELECTROSHOCK THERAPY			17,975	0 76.00
76.97 07697	CARDIAC REHABILITATION			0	0 76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY			0	0 76.98
76.99 07699	LITHOTRIPSY			0	0 76.99
OUTPATIENT SERVICE COST CENTERS					
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0 92.00
93.00 04950	PARTIAL HOSPITALIZATION			140,651	0 93.00
OTHER REIMBURSABLE COST CENTERS					
94.00 09400	HOME PROGRAM DIALYSIS			0	0 94.00
SPECIAL PURPOSE COST CENTERS					
113.00 11300	INTEREST EXPENSE				113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	1,336,906 0 118.00
NONREIMBURSABLE COST CENTERS					
191.00 19100	RESEARCH			2,832	0 191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES			312,883	0 192.00
194.00 07950	DUI PROGRAM			434	0 194.00
194.01 07951	IPPS			10,045	0 194.01
194.02 07952	RESIDENTIAL CENTER			7,456	0 194.02
200.00	Cross Foot Adjustments	0	0	15,410	0 200.00
201.00	Negative Cost Centers	0	0	0	-463,901 0 201.00
202.00	TOTAL (sum lines 118 through 201)	0	0	15,410	1,222,065 0 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-4031	Period: From 07/01/2017 To 06/30/2018	Worksheet B Part II Date/Time Prepared: 11/28/2018 11:36 am
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	1,144,394
ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	396
60.00	06000	LABORATORY	3,848
66.00	06600	PHYSICAL THERAPY	2,624
69.00	06900	ELECTROCARDIOLOGY	0
73.00	07300	DRUGS CHARGED TO PATIENTS	27,018
74.00	07400	RENAL DIALYSIS	0
76.00	03320	ELECTROSHOCK THERAPY	17,975
76.97	07697	CARDIAC REHABILITATION	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0
76.99	07699	LITHOTRIpsy	0
OUTPATIENT SERVICE COST CENTERS			
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	
93.00	04950	PARTIAL HOSPITALIZATION	140,651
OTHER REIMBURSABLE COST CENTERS			
94.00	09400	HOME PROGRAM DIALYSIS	0
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,336,906
NONREIMBURSABLE COST CENTERS			
191.00	19100	RESEARCH	2,832
192.00	19200	PHYSICIANS' PRIVATE OFFICES	312,883
194.00	07950	DUI PROGRAM	434
194.01	07951	IPPS	10,045
194.02	07952	RESIDENTIAL CENTER	7,456
200.00		Cross Foot Adjustments	15,410
201.00		Negative Cost Centers	-463,901
202.00		TOTAL (sum lines 118 through 201)	1,222,065

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-4031

Period:
From 07/01/2017
To 06/30/2018

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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	127,270				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		127,270			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	41,292,360		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	39,212	39,212	7,964,344	-36,696,209	45,564,457
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00 00700	OPERATION OF PLANT	597	597	0	0	703,364
8.00 00800	LAUNDRY & LINEN SERVICE	265	265	0	0	60,066
9.00 00900	HOUSEKEEPING	149	149	139,832	0	1,034,808
10.00 01000	DIETARY	1,672	1,672	262,095	0	2,032,765
11.00 01100	CAFETERIA	2,703	2,703	52,012	0	115,521
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	0	0	1,321,060	0	1,779,572
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00 01500	PHARMACY	0	0	0	0	0
16.00 01600	MEDICAL RECORDS & LIBRARY	1,066	1,066	416,399	0	1,010,321
17.00 01700	SOCIAL SERVICE	0	0	0	0	0
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00 02000	NURSING SCHOOL	0	0	0	0	0
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
23.00 02300	PARAMED ED PRGM-(SPECIFY)	462	462	596,685	0	759,847
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	59,238	59,238	14,260,988	0	20,780,965
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	343	0	34,123
60.00 06000	LABORATORY	0	0	0	0	209,440
66.00 06600	PHYSICAL THERAPY	0	0	166,752	0	205,971
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	455	455	0	0	1,655,272
74.00 07400	RENAL DIALYSIS	0	0	0	0	0
76.00 03320	ELECTROSHOCK THERAPY	616	616	503,177	0	725,984
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98 07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0
76.99 07699	LITHOTRI PSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.00 04950	PARTIAL HOSPITALIZATION	5,548	5,548	3,114,381	0	4,221,397
OTHER REIMBURSABLE COST CENTERS						
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	111,983	111,983	28,798,068	-36,696,209	35,329,416
NONREIMBURSABLE COST CENTERS						
191.00 19100	RESEARCH	206	206	0	0	2,798
192.00 19200	PHYSICIANS' PRIVATE OFFICES	15,081	15,081	11,324,853	0	8,801,395
194.00 07950	DUI PROGRAM	0	0	28,054	0	34,658
194.01 07951	IPPS	0	0	605,750	0	742,166
194.02 07952	RESIDENTIAL CENTER	0	0	535,635	0	654,024
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,685,966	-463,901	6,266,084		36,696,209
203.00	Unit cost multiplier (Wkst. B, Part I)	13.247160	0.000000	0.151749		0.805369
204.00	Cost to be allocated (per Wkst. B, Part II)			0		519,448
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.011400
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-4031

Period:
From 07/01/2017
To 06/30/2018

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Date/Time Prepared:
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Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	0					6.00
7.00	00700		87,461				7.00
8.00	00800		265	100			8.00
9.00	00900	0	149		87,047		9.00
10.00	01000	0	1,672	0	1,672	45,139	10.00
11.00	01100	0	2,703	0	2,703	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	0	0	0	0	0	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	0	1,066	0	1,066	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	462	0	462	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	59,238	100	59,238	45,139	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	0	0	0	0	54.00
60.00	06000	0	0	0	0	0	60.00
66.00	06600	0	0	0	0	0	66.00
69.00	06900	0	0	0	0	0	69.00
73.00	07300	0	455	0	455	0	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03320	0	616	0	616	0	76.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200						92.00
93.00	04950	0	5,548	0	5,548	0	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		0	72,174	100	71,760	45,139	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100	0	206	0	206	0	191.00
192.00	19200	0	15,081	0	15,081	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00							201.00
202.00		0	1,269,832	112,288	1,870,373	3,730,092	202.00
203.00		0.000000	14.518837	1,122.880000	21.486932	82.635681	203.00
204.00		0	15,927	4,243	13,798	45,892	204.00
205.00		0.000000	0.182104	42.430000	0.158512	1.016682	205.00
206.00							206.00
207.00							207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-4031

Period:
From 07/01/2017
To 06/30/2018

Worksheet B-1

Date/Time Prepared:
11/28/2018 11:36 am

Cost Center Description		CAFETERIA (FULL TIME EQUIV'S)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	43,465					11.00
12.00	01200	0	0				12.00
13.00	01300	1,396	0	597,359			13.00
14.00	01400	0	0	0	0		14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	930	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	538	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	23,012	0	483,596	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	0	0	0	0	54.00
60.00	06000	0	0	0	0	0	60.00
66.00	06600	189	0	0	0	0	66.00
69.00	06900	0	0	0	0	0	69.00
73.00	07300	726	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03320	634	0	0	0	0	76.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200						92.00
93.00	04950	5,469	0	113,763	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		32,894	0	597,359	0	0	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100	0	0	0	0	0	191.00
192.00	19200	8,717	0	0	0	0	192.00
194.00	07950	44	0	0	0	0	194.00
194.01	07951	1,810	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00							201.00
202.00		305,881	0	3,222,608	0	0	202.00
203.00		7.037409	0.000000	5.394759	0.000000	0.000000	203.00
204.00		38,044	0	21,509	0	0	204.00
205.00		0.875279	0.000000	0.036007	0.000000	0.000000	205.00
206.00							206.00
207.00							207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-4031

Period:
From 07/01/2017
To 06/30/2018

Worksheet B-1

Date/Time Prepared:
11/28/2018 11:36 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	
		16.00	17.00	19.00	20.00	21.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	152,572,571				16.00
17.00	01700	SOCIAL SERVICE	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0		0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	84,708,498	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	37,327	0	0	0	54.00
60.00	06000	LABORATORY	8,297,851	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	631,862	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,564,309	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03320	ELECTROSHOCK THERAPY	4,398,290	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.00	04950	PARTIAL HOSPITALIZATION	46,934,434	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	152,572,571	0	0	0	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	DUI PROGRAM	0	0	0	0	194.00
194.01	07951	IPPS	0	0	0	0	194.01
194.02	07952	RESIDENTIAL CENTER	0	0	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,868,929	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.012249	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	26,816	0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000176	0.000000	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000	207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-4031

Period:
From 07/01/2017
To 06/30/2018

Worksheet B-1
Date/Time Prepared:
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Cost Center Description	INTERNS & RESIDENTS	PARAMED PRGM (ASSIGNED TIME)	
	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
	22.00	23.00	
GENERAL SERVICE COST CENTERS			
1.00 00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00 00500	ADMINISTRATIVE & GENERAL		5.00
6.00 00600	MAINTENANCE & REPAIRS		6.00
7.00 00700	OPERATION OF PLANT		7.00
8.00 00800	LAUNDRY & LINEN SERVICE		8.00
9.00 00900	HOUSEKEEPING		9.00
10.00 01000	DIETARY		10.00
11.00 01100	CAFETERIA		11.00
12.00 01200	MAINTENANCE OF PERSONNEL		12.00
13.00 01300	NURSING ADMINISTRATION		13.00
14.00 01400	CENTRAL SERVICES & SUPPLY		14.00
15.00 01500	PHARMACY		15.00
16.00 01600	MEDICAL RECORDS & LIBRARY		16.00
17.00 01700	SOCIAL SERVICE		17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS		19.00
20.00 02000	NURSING SCHOOL		20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	22.00
23.00 02300	PARAMED PRGM-(SPECIFY)	100	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 03000	ADULTS & PEDIATRICS	0	25
ANCILLARY SERVICE COST CENTERS			
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0
60.00 06000	LABORATORY	0	0
66.00 06600	PHYSICAL THERAPY	0	0
69.00 06900	ELECTROCARDIOLOGY	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0
74.00 07400	RENAL DIALYSIS	0	0
76.00 03320	ELECTROSHOCK THERAPY	0	0
76.97 07697	CARDIAC REHABILITATION	0	0
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0
76.99 07699	LITHOTRIPSY	0	0
OUTPATIENT SERVICE COST CENTERS			
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
93.00 04950	PARTIAL HOSPITALIZATION	0	75
OTHER REIMBURSABLE COST CENTERS			
94.00 09400	HOME PROGRAM DIALYSIS	0	0
SPECIAL PURPOSE COST CENTERS			
113.00 11300	INTEREST EXPENSE		113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	100
NONREIMBURSABLE COST CENTERS			
191.00 19100	RESEARCH	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0
194.00 07950	DUI PROGRAM	0	0
194.01 07951	IPPS	0	0
194.02 07952	RESIDENTIAL CENTER	0	0
200.00	Cross Foot Adjustments		200.00
201.00	Negative Cost Centers		201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	0	1,392,225
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	13,922.250000
204.00	Cost to be allocated (per Wkst. B, Part II)	0	15,410
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	154.100000
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)		0
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4031

Period:
From 07/01/2017
To 06/30/2018

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE		Total Costs
					Disallowance		
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	47,649,156		47,649,156	0	47,649,156	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400 RADIOLOGY-DIAGNOSTIC	62,062		62,062	0	62,062	54.00
60.00	06000 LABORATORY	479,756		479,756	0	479,756	60.00
66.00	06600 PHYSICAL THERAPY	380,924	0	380,924	0	380,924	66.00
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0	69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,102,524		3,102,524	0	3,102,524	73.00
74.00	07400 RENAL DIALYSIS	0		0	0	0	74.00
76.00	03320 ELECTROSHOCK THERAPY	1,391,186		1,391,186	0	1,391,186	76.00
76.97	07697 CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699 LI THOTRI PSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
93.00	04950 PARTIAL HOSPITALIZATION	10,092,220		10,092,220	0	10,092,220	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0		0	0	0	94.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	63,157,828	0	63,157,828	0	63,157,828	200.00
201.00	Less Observation Beds	0		0		0	201.00
202.00	Total (see instructions)	63,157,828	0	63,157,828	0	63,157,828	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4031

Period:
From 07/01/2017
To 06/30/2018

Worksheet C
Part I
Date/Time Prepared:
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		Title XVIII			Hospital	PPS		
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
		Inpatient	Outpatient	Total (col. 6 + col. 7)				
		6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	84,708,498		84,708,498			30.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	37,327	0	37,327	1.662657	0.000000	54.00
60.00	06000	LABORATORY	8,266,804	31,047	8,297,851	0.057817	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	631,862	0	631,862	0.602859	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,907,250	657,059	7,564,309	0.410153	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
76.00	03320	ELECTROSHOCK THERAPY	2,401,765	1,996,525	4,398,290	0.316302	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
93.00	04950	PARTIAL HOSPITALIZATION	5,855	46,928,579	46,934,434	0.215028	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	0.000000	94.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	102,959,361	49,613,210	152,572,571			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	102,959,361	49,613,210	152,572,571			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-4031	Period: From 07/01/2017 To 06/30/2018	Worksheet C Part I Date/Time Prepared: 11/28/2018 11:36 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
ANCILLARY SERVICE COST CENTERS				
54.00	05400 RADIOLOGY-DIAGNOSTIC	1.662657		54.00
60.00	06000 LABORATORY	0.057817		60.00
66.00	06600 PHYSICAL THERAPY	0.602859		66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.410153		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
76.00	03320 ELECTROSHOCK THERAPY	0.316302		76.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699 LI THOTRI PSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04950 PARTIAL HOSPITALIZATION	0.215028		93.00
OTHER REIMBURSABLE COST CENTERS				
94.00	09400 HOME PROGRAM DIALYSIS	0.000000		94.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4031

Period:
From 07/01/2017
To 06/30/2018

Worksheet C
Part I
Date/Time Prepared:
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		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	47,649,156		47,649,156	0	47,649,156 30.00
ANCILLARY SERVICE COST CENTERS						
54.00	05400 RADIOLOGY-DIAGNOSTIC	62,062		62,062	0	62,062 54.00
60.00	06000 LABORATORY	479,756		479,756	0	479,756 60.00
66.00	06600 PHYSICAL THERAPY	380,924	0	380,924	0	380,924 66.00
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0 69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,102,524		3,102,524	0	3,102,524 73.00
74.00	07400 RENAL DIALYSIS	0		0	0	0 74.00
76.00	03320 ELECTROSHOCK THERAPY	1,391,186		1,391,186	0	1,391,186 76.00
76.97	07697 CARDIAC REHABILITATION	0		0	0	0 76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0		0	0	0 76.98
76.99	07699 LI THOTRI PSY	0		0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS						
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		0		0 92.00
93.00	04950 PARTIAL HOSPITALIZATION	10,092,220		10,092,220	0	10,092,220 93.00
OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0		0	0	0 94.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					
200.00	Subtotal (see instructions)	63,157,828	0	63,157,828	0	63,157,828 200.00
201.00	Less Observation Beds	0		0		0 201.00
202.00	Total (see instructions)	63,157,828	0	63,157,828	0	63,157,828 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4031

Period:
From 07/01/2017
To 06/30/2018

Worksheet C
Part I
Date/Time Prepared:
11/28/2018 11:36 am

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	84,708,498		84,708,498		30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	37,327	0	37,327	1.662657	54.00
60.00	06000	LABORATORY	8,266,804	31,047	8,297,851	0.057817	60.00
66.00	06600	PHYSICAL THERAPY	631,862	0	631,862	0.602859	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,907,250	657,059	7,564,309	0.410153	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	74.00
76.00	03320	ELECTROSHOCK THERAPY	2,401,765	1,996,525	4,398,290	0.316302	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	92.00
93.00	04950	PARTIAL HOSPITALIZATION	5,855	46,928,579	46,934,434	0.215028	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	94.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	102,959,361	49,613,210	152,572,571		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	102,959,361	49,613,210	152,572,571		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-4031	Period: From 07/01/2017 To 06/30/2018	Worksheet C Part I Date/Time Prepared: 11/28/2018 11:36 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
ANCILLARY SERVICE COST CENTERS				
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
76.00	03320 ELECTROSHOCK THERAPY	0.000000		76.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699 LI THOTRI PSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04950 PARTIAL HOSPITALIZATION	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS				
94.00	09400 HOME PROGRAM DIALYSIS	0.000000		94.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-4031		Period: From 07/01/2017 To 06/30/2018		Worksheet D Part I Date/Time Prepared: 11/28/2018 11:36 am	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	1,144,394	0	1,144,394	45,139	25.35	30.00
200.00	Total (lines 30 through 199)	1,144,394		1,144,394	45,139		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	12,921	327,547				
200.00	Total (lines 30 through 199)	12,921	327,547				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 14-4031	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part II Date/Time Prepared: 11/28/2018 11:36 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
54.00	05400 RADIOLOGY-DIAGNOSTIC	396	37,327	0.010609	28,873	306	54.00
60.00	06000 LABORATORY	3,848	8,297,851	0.000464	1,992,035	924	60.00
66.00	06600 PHYSICAL THERAPY	2,624	631,862	0.004153	439,210	1,824	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	27,018	7,564,309	0.003572	2,480,779	8,861	73.00
74.00	07400 RENAL DIALYSIS	0	0	0.000000	0	0	74.00
76.00	03320 ELECTROSHOCK THERAPY	17,975	4,398,290	0.004087	1,351,753	5,525	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
93.00	04950 PARTIAL HOSPITALIZATION	140,651	46,934,434	0.002997	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00	Total (lines 50 through 199)	192,512	67,864,073		6,292,650	17,440	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-4031		Period: From 07/01/2017 To 06/30/2018		Worksheet D Part III Date/Time Prepared: 11/28/2018 11:36 am		
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	348,056	0	30.00	
200.00		Total (lines 30 through 199)	0	0	0	348,056	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days		
			4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	348,056	45,139	7.71	12,921	30.00	
200.00		Total (lines 30 through 199)		348,056	45,139		12,921	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	99,621						30.00
200.00		Total (lines 30 through 199)	99,621						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-4031	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/28/2018 11:36 am
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Cost Center Description	Title XVIII			Hospital		Allied Health
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	PPS	
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00 03320 ELECTROSHOCK THERAPY	0	0	0	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99 07699 LI THOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
93.00 04950 PARTIAL HOSPITALIZATION	0	0	0	0	1,044,169	93.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00 Total (lines 50 through 199)	0	0	0	0	1,044,169	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-4031	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/28/2018 11:36 am
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Cost Center Description		Title XVIII			Hospital	PPS		
		All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	37,327	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	8,297,851	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	631,862	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,564,309	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
76.00	03320	ELECTROSHOCK THERAPY	0	0	0	4,398,290	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000	92.00
93.00	04950	PARTIAL HOSPITALIZATION	0	1,044,169	1,044,169	46,934,434	0.022247	93.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0.000000	94.00
200.00		Total (lines 50 through 199)	0	1,044,169	1,044,169	67,864,073		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-4031

Period:
From 07/01/2017
To 06/30/2018

Worksheet D
Part IV
Date/Time Prepared:
11/28/2018 11:36 am

Cost Center Description			Title XVIII			Hospital		PPS	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS									
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	28,873	0	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	1,992,035	0	24,884	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.000000	439,210	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,480,779	0	256,160	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	0	74.00
76.00	03320	ELECTROSHOCK THERAPY	0.000000	1,351,753	0	1,177,354	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
93.00	04950	PARTIAL HOSPITALIZATION	0.022247	0	0	2,024,243	45,033	0	93.00
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	0	94.00
200.00		Total (lines 50 through 199)		6,292,650	0	3,482,641	45,033	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-4031	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part V Date/Time Prepared: 11/28/2018 11:36 am
Title XVIII		Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	1.662657	0	0	0	54.00
60.00	06000	LABORATORY	0.057817	24,884	0	1,439	60.00
66.00	06600	PHYSICAL THERAPY	0.602859	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.410153	256,160	0	1,444	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	74.00
76.00	03320	ELECTROSHOCK THERAPY	0.316302	1,177,354	0	372,399	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	76.98
76.99	07699	LITHOTRIpsy	0.000000	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	92.00
93.00	04950	PARTIAL HOSPITALIZATION	0.215028	2,024,243	0	435,269	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	0	94.00
200.00		Subtotal (see instructions)		3,482,641	0	1,444	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net Charges (line 200 - line 201)		3,482,641	0	1,444	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-4031	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part V Date/Time Prepared: 11/28/2018 11:36 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00 06000	LABORATORY	0	0	60.00
66.00 06600	PHYSICAL THERAPY	0	0	66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	69.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	592	73.00
74.00 07400	RENAL DIALYSIS	0	0	74.00
76.00 03320	ELECTROSHOCK THERAPY	0	0	76.00
76.97 07697	CARDIAC REHABILITATION	0	0	76.97
76.98 07698	HYPERBARI C OXYGEN THERAPY	0	0	76.98
76.99 07699	LITHOTRI PSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS				
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
93.00 04950	PARTIAL HOSPITALIZATION	0	0	93.00
OTHER REIMBURSABLE COST CENTERS				
94.00 09400	HOME PROGRAM DIALYSIS	0	0	94.00
200.00	Subtotal (see instructions)	0	592	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	0	592	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-4031	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/28/2018 11:36 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		45,139	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		45,139	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		45,139	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		12,921	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		47,649,156	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		47,649,156	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		47,649,156	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,055.61	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		13,639,537	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		13,639,537	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-4031	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/28/2018 11:36 am
Cost Center Description			Title XVIII	Hospital	PPS
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)				42.00
Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT				43.00
44.00	CORONARY CARE UNIT				44.00
45.00	BURN INTENSIVE CARE UNIT				45.00
46.00	SURGICAL INTENSIVE CARE UNIT				46.00
47.00	OTHER SPECIAL CARE (SPECIFY)				47.00
Cost Center Description					
					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				1,873,022
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				15,512,559
PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				427,168
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				17,440
52.00	Total Program excludable cost (sum of lines 50 and 51)				444,608
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				15,067,951
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges				0
55.00	Target amount per discharge				0.00
56.00	Target amount (line 54 x line 55)				0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0
58.00	Bonus payment (see instructions)				0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0
62.00	Relief payment (see instructions)				0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)				70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				71.00
72.00	Program routine service cost (line 9 x line 71)				72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)				73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)				74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)				76.00
77.00	Program capital-related costs (line 9 x line 76)				77.00
78.00	Inpatient routine service cost (line 74 minus line 77)				78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)				79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				80.00
81.00	Inpatient routine service cost per diem limitation				81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)				82.00
83.00	Reasonable inpatient routine service costs (see instructions)				83.00
84.00	Program inpatient ancillary services (see instructions)				84.00
85.00	Utilization review - physician compensation (see instructions)				85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)				86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)				0
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-4031		Period: From 07/01/2017 To 06/30/2018		Worksheet D-1 Date/Time Prepared: 11/28/2018 11:36 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,144,394	47,649,156	0.024017	0	0	90.00
91.00	Nursing School cost	0	47,649,156	0.000000	0	0	91.00
92.00	Allied health cost	348,056	47,649,156	0.007305	0	0	92.00
93.00	All other Medical Education	0	47,649,156	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-4031	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/28/2018 11:36 am
Cost Center Description		Title XIX	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		45,139	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		45,139	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		45,139	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		897	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		47,649,156	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		47,649,156	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		47,649,156	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,055.61	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		946,882	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		946,882	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-4031	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/28/2018 11:36 am
Cost Center Description			Title XIX		Hospital
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)				42.00
Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT				43.00
44.00	CORONARY CARE UNIT				44.00
45.00	BURN INTENSIVE CARE UNIT				45.00
46.00	SURGICAL INTENSIVE CARE UNIT				46.00
47.00	OTHER SPECIAL CARE (SPECIFY)				47.00
Cost Center Description					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				0 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				946,882 49.00
PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				0 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				0 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges				0 54.00
55.00	Target amount per discharge				0.00 55.00
56.00	Target amount (line 54 x line 55)				0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0 57.00
58.00	Bonus payment (see instructions)				0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00 59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00 60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0 61.00
62.00	Relief payment (see instructions)				0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)				70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				71.00
72.00	Program routine service cost (line 9 x line 71)				72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)				73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)				74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)				76.00
77.00	Program capital-related costs (line 9 x line 76)				77.00
78.00	Inpatient routine service cost (line 74 minus line 77)				78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)				79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				80.00
81.00	Inpatient routine service cost per diem limitation				81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)				82.00
83.00	Reasonable inpatient routine service costs (see instructions)				83.00
84.00	Program inpatient ancillary services (see instructions)				84.00
85.00	Utilization review - physician compensation (see instructions)				85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)				86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)				0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-4031		Period: From 07/01/2017 To 06/30/2018		Worksheet D-1 Date/Time Prepared: 11/28/2018 11:36 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,144,394	47,649,156	0.024017	0	0	90.00
91.00	Nursing School cost	0	47,649,156	0.000000	0	0	91.00
92.00	Allied health cost	0	47,649,156	0.000000	0	0	92.00
93.00	All other Medical Education	0	47,649,156	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-4031	Period: From 07/01/2017 To 06/30/2018	Worksheet D-3 Date/Time Prepared: 11/28/2018 11:36 am	
Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		24,270,971		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	1.662657	28,873	48,006	54.00
60.00	06000 LABORATORY	0.057817	1,992,035	115,173	60.00
66.00	06600 PHYSICAL THERAPY	0.602859	439,210	264,782	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.410153	2,480,779	1,017,499	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	74.00
76.00	03320 ELECTROSHOCK THERAPY	0.316302	1,351,753	427,562	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
93.00	04950 PARTIAL HOSPITALIZATION	0.215028	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400 HOME PROGRAM DIALYSIS	0.000000	0	0	94.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		6,292,650	1,873,022	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		6,292,650		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-4031	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/28/2018 11:36 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		592	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		869,139	2.00
3.00	OPPS payments		839,983	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		45,033	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		592	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		1,444	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		1,444	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		1,444	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		852	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		592	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		885,016	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		168,403	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		717,205	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		717,205	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		717,205	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		50,383	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		32,749	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		42,692	36.00
37.00	Subtotal (see instructions)		749,954	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		749,954	40.00
40.01	Sequestration adjustment (see instructions)		14,999	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		721,132	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		13,823	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-4031

Period:
From 07/01/2017
To 06/30/2018

Worksheet E-1
Part I
Date/Time Prepared:
11/28/2018 11:36 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		10,798,823		658,482		1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		374,419		23,550		2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	01/30/2018	31,200	01/30/2018	39,100		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		31,200		39,100		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		11,204,442		721,132		4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0		5.50
5.51			0		0		5.51
5.52			0		0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		13,823		6.01
6.02	SETTLEMENT TO PROGRAM		77,026		0		6.02
7.00	Total Medicare program liability (see instructions)		11,127,416		734,955		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-4031	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part II Date/Time Prepared: 11/28/2018 11:36 am
		Title XVIII	Hospital	PPS
		1.00		
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			11,656,366 1.00
2.00	Net IPF PPS Outlier Payments			40,921 2.00
3.00	Net IPF PPS ECT Payments			308,685 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			123.668493 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			12,005,972 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			12,005,972 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			12,005,972 18.00
19.00	Deductibles			648,732 19.00
20.00	Subtotal (line 18 minus line 19)			11,357,240 20.00
21.00	Coinsurance			337,968 21.00
22.00	Subtotal (line 20 minus line 21)			11,019,272 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			362,481 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			235,613 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			311,896 25.00
26.00	Subtotal (sum of lines 22 and 24)			11,254,885 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			99,621 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			11,354,506 31.00
31.01	Sequestration adjustment (see instructions)			227,090 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			11,204,442 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			-77,026 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			40,921 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-4031	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part VII Date/Time Prepared: 11/28/2018 11:36 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		946,882		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		946,882	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		946,882	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		946,882	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		946,882	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 14-4031

Period:
From 07/01/2017
To 06/30/2018

Worksheet G

Date/Time Prepared:
11/28/2018 11:36 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	98,449	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	10,696,037	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	133,428	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	5,924,763	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	16,852,677	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,540,000	0	0	0	12.00
13.00	Land improvements	267,675	0	0	0	13.00
14.00	Accumulated depreciation	-105,320	0	0	0	14.00
15.00	Buildings	23,886,397	0	0	0	15.00
16.00	Accumulated depreciation	-4,642,102	0	0	0	16.00
17.00	Leasehold improvements	50,696	0	0	0	17.00
18.00	Accumulated depreciation	-31,545	0	0	0	18.00
19.00	Fixed equipment	440,615	0	0	0	19.00
20.00	Accumulated depreciation	-158,553	0	0	0	20.00
21.00	Automobiles and trucks	64,857	0	0	0	21.00
22.00	Accumulated depreciation	-25,757	0	0	0	22.00
23.00	Major movable equipment	3,861,203	0	0	0	23.00
24.00	Accumulated depreciation	-1,441,799	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	23,706,367	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	30,980	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	30,980	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	40,590,024	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	20,113,114	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	20,113,114	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	-253	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-253	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	20,112,861	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	20,477,163				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	20,477,163	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	40,590,024	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-4031

Period:
From 07/01/2017
To 06/30/2018

Worksheet G-1

Date/Time Prepared:
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		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		21,399,036			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-800,307				2.00
3.00	Total (sum of line 1 and line 2)		20,598,729			0	3.00
4.00	TRANSFERS TO AFFILIATES	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0			0	10.00
11.00	Subtotal (line 3 plus line 10)		20,598,729			0	11.00
12.00	TRANSFERS TO AFFILIATES	121,566		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		121,566			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		20,477,163			0	19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	TRANSFERS TO AFFILIATES		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	TRANSFERS TO AFFILIATES		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-4031

Period:
From 07/01/2017
To 06/30/2018

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/28/2018 11:36 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	84,979,857		84,979,857	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	84,979,857		84,979,857	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	84,979,857		84,979,857	17.00
18.00	Ancillary services	18,250,863		18,250,863	18.00
19.00	Outpatient services	0	50,203,705	50,203,705	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	RESEARCH	9,000	0	9,000	27.00
27.01	PHYSICIAN PRIVATE OFFICE	0	22,706,899	22,706,899	27.01
27.02	47	0	14,532	14,532	27.02
27.03	RESIDENTIAL TREATMENT	5,363,055	0	5,363,055	27.03
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	108,602,775	72,925,136	181,527,911	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		86,144,933		29.00
30.00	+	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		86,144,933		43.00

STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 14-4031	Period: From 07/01/2017 To 06/30/2018	Worksheet G-3 Date/Time Prepared: 11/28/2018 11:36 am
		1.00		
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	181,527,911		1.00
2.00	Less contractual allowances and discounts on patients' accounts	99,766,057		2.00
3.00	Net patient revenues (line 1 minus line 2)	81,761,854		3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	86,144,933		4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,383,079		5.00
OTHER INCOME				
6.00	Contributions, donations, bequests, etc	0		6.00
7.00	Income from investments	0		7.00
8.00	Revenues from telephone and other miscellaneous communication services	0		8.00
9.00	Revenue from television and radio service	0		9.00
10.00	Purchase discounts	0		10.00
11.00	Rebates and refunds of expenses	0		11.00
12.00	Parking lot receipts	0		12.00
13.00	Revenue from laundry and linen service	0		13.00
14.00	Revenue from meals sold to employees and guests	204,704		14.00
15.00	Revenue from rental of living quarters	0		15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0		16.00
17.00	Revenue from sale of drugs to other than patients	0		17.00
18.00	Revenue from sale of medical records and abstracts	397		18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0		19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0		20.00
21.00	Rental of vending machines	0		21.00
22.00	Rental of hospital space	0		22.00
23.00	Governmental appropriations	0		23.00
24.00	GRANT INCOME	107,815		24.00
24.01	INTEREST INCOME	25,686		24.01
24.02	RESTRICTED FUNDS	499,379		24.02
24.03	OTHER OPERATING	855,849		24.03
24.04	OTHER MISC REVENUE	1,245,254		24.04
24.05	RESEARCH INCOME	92,368		24.05
24.06	UNCLAIMED PROPERTY EXEMPTIONS	9,043		24.06
24.07	UNRESTRICTED DONATIONS REVENUE	542,285		24.07
24.08	OTHER (SPECIFY)	0		24.08
24.09	OTHER (SPECIFY)	0		24.09
24.10	OTHER (SPECIFY)	0		24.10
24.11	OTHER (SPECIFY)	0		24.11
24.12	OTHER (SPECIFY)	0		24.12
24.13	OTHER (SPECIFY)	0		24.13
24.14	OTHER (SPECIFY)	0		24.14
24.15	OTHER (SPECIFY)	0		24.15
24.16	OTHER (SPECIFY)	0		24.16
24.17	OTHER (SPECIFY)	0		24.17
25.00	Total other income (sum of lines 6-24)	3,582,780		25.00
26.00	Total (line 5 plus line 25)	-800,299		26.00
27.00	RECONCILING AMOUNT	8		27.00
28.00	Total other expenses (sum of line 27 and subscripts)	8		28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-800,307		29.00