

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: 14-0002

Period:
From 01/01/2018
To 12/31/2018

Worksheet S
Parts I-III
Date/Time Prepared:
5/24/2019 2:50 pm

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 5/24/2019	Time: 2:50 pm
	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 (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ALTON MEMORIAL HOSPITAL (14-0002) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)_____
Title_____
Date

Cost Center Description		Title V	Title XVIII		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	13,113	39,753	0	0	1.00
2.00	Subprovider - IPF	0	39,112	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	52,225	39,753	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: 14-0002		Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part I Date/Time Prepared: 5/24/2019 2:49 pm			
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: ONE MEMORIAL DRIVE			PO Box:							1.00
2.00	City: ALTON			State: IL		Zip Code: 62002-		County: MADISON			2.00
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
								V	XVIII	XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		ALTON MEMORIAL HOSPITAL	140002	41180	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF		ALTON MEMORIAL HOSPITAL PSYCH	14S002	41180	4	01/01/2008	N	P	N	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)						01/01/2018	12/31/2018		20.00	
21.00	Type of Control (see instructions)						2			21.00	
							1.00	2.00	3.00		
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y			22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			23.00	
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
				1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			704	1,071	27	8	2,559	0	24.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet S-2
Part I
Date/Time Prepared:
5/24/2019 2:49 pm

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
					Urban/Rural S	Date of Geogr	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N	Y/N	
					1.00	2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	Y	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
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		
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.							
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		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1.00	2.00	3.00	
60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)				N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet S-2
Part I
Date/Time Prepared:
5/24/2019 2:49 pm

	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00		2.00	3.00	4.00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
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)		0.00	0.00	0.000000		64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet S-2
Part I
Date/Time Prepared:
5/24/2019 2:49 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0002	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/24/2019 2:49 pm	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		Y	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		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.	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
		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: 14-0002	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/24/2019 2:49 pm	
			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.	2			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	3,517,500	1,297,000	118.01
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		269026	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0002		Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part I Date/Time Prepared: 5/24/2019 2:49 pm	
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: BJC HEALTH SYSTEM		Contractor's Name: WPS		Contractor's Number: 05301				141.00
142.00	Street: 4901 FOREST PARK AVENUE		PO Box:						142.00
143.00	City: ST. LOUIS		State: MO		Zip Code: 63108				143.00
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							Y	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.							N	146.00
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital			N	N	N	N		
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		
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					07/24/2018	10/21/2018		170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N	0		171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0002	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/24/2019 2:49 pm
			Y/N 1.00	Date 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 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		Y	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 1.00	Date 2.00	Y/N 3.00
				Date 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)	Y	04/05/2019	Y
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)	N		N
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		Y
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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet S-2
Part II
Date/Time Prepared:
5/24/2019 2:49 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		Y		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		Y		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PAUL	BRADSHAW		41.00
42.00	Enter the employer/company name of the cost report preparer.	BJC HEALTHCARE			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-362-7419	PJB1541@BJC.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0002	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/24/2019 2:49 pm
		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.	REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

VOLUNTARY CONTACT INFORMATION

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet S-2
Part V
Date/Time Prepared:
5/24/2019 2:49 pm

		1.00	
Cost Report Preparer Contact Information			
1.00	First Name	PAUL	1.00
2.00	Last Name	BRADSHAW	2.00
3.00	Title	REIMBURSEMENT MANAGER	3.00
4.00	Employer	BJC HEALTH CARE	4.00
5.00	Phone Number	(314)362-7419	5.00
6.00	E-mail Address	PAUL.BRADSHAW@BJC.ORG	6.00
7.00	Department	BJC @ THE COMMONS	7.00
8.00	Mailing Address 1	MAILSTOP 90-67-808	8.00
9.00	Mailing Address 2	4249 CLAYTON AVE.	9.00
10.00	City	ST. LOUIS	10.00
11.00	State	MO	11.00
12.00	Zip	63110	12.00
Officer or Administrator of Provider Contact Information			
13.00	First Name		13.00
14.00	Last Name		14.00
15.00	Title		15.00
16.00	Employer		16.00
17.00	Phone Number		17.00
18.00	E-mail Address		18.00
19.00	Department		19.00
20.00	Mailing Address 1		20.00
21.00	Mailing Address 2		21.00
22.00	City		22.00
23.00	State		23.00
24.00	Zip		24.00

HFS Supplemental Information

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet S-2
Part IX
Date/Time Prepared:
5/24/2019 2:49 pm

		Title V	Title XIX	
		1.00	2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.01)	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.02)	Y	Y	3.00
3.01	Do Title V or XIX use W/S D-1 for reimbursement?	N	N	3.01
		Inpatient	Outpatient	
		1.00	2.00	
CRITICAL ACCESS HOSPITALS				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
RCE DISALLOWANCE				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.05)	Y	Y	6.00
PASS THROUGH COST				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.06)	Y	Y	7.00
RHC				
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	8.00
FQHC				
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	9.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet S-3
Part I
Date/Time Prepared:
5/24/2019 2:49 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	120	43,800	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)		120	43,800	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,380	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		132	48,180	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	20	7,300		0	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)		152			0	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: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet S-3
Part I
Date/Time Prepared:
5/24/2019 2:49 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	9,507	1,733	21,778			1.00
2.00	HMO and other (see instructions)	4,220	2,559				2.00
3.00	HMO IPF Subprovider	605	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	9,507	1,733	21,778			7.00
8.00	INTENSIVE CARE UNIT	1,066	77	2,321			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)	10,573	1,810	24,099	0.00	693.53	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,939	0	2,726	0.00	15.97	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			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	709.50	27.00
28.00	Observation Bed Days		0	2,158			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: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet S-3
Part I
Date/Time Prepared:
5/24/2019 2:49 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,623	477	7,386	1.00
2.00 HMO and other (see instructions)			1,128	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	2,623	477	7,386	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	170	0	265	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: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet S-3
Part II
Date/Time Prepared:
5/24/2019 2:49 pm

	Wkst. A Line Number	Amount Reported	Reclassificati on 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	44,221,219	0	44,221,219	1,479,762.00	29.88
2.00	Non-physician anesthetist Part A		142,159	0	142,159	852.00	166.85
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		4,099,181	26,548	4,125,729	178,634.00	23.10
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		606,537	0	606,537	7,835.00	77.41
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		443,875	0	443,875	4,284.00	103.61
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		8,670,222	0	8,670,222	189,026.00	45.87
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		11,973,333	0	11,973,333		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		661,227	0	661,227		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		38,315	0	38,315		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		1,415,317	0	1,415,317		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	1,532,315	0	1,532,315	80,815.00	18.96
27.00	Administrative & General	5.00	2,992,452	0	2,992,452	58,393.00	51.25

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet S-3
Part II
Date/Time Prepared:
5/24/2019 2:49 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on 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.)		2,246,287	0	2,246,287	21,962.00	102.28	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	847,485	0	847,485	32,302.00	26.24	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,091,412	0	1,091,412	78,938.00	13.83	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		1,768,837	0	1,768,837	77,147.00	22.93	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	957,605	0	957,605	24,087.00	39.76	38.00
39.00	Central Services and Supply	14.00	241,187	0	241,187	11,964.00	20.16	39.00
40.00	Pharmacy	15.00	1,860,530	0	1,860,530	42,769.00	43.50	40.00
41.00	Medical Records & Medical Records Library	16.00	158,243	0	158,243	9,029.00	17.53	41.00
42.00	Social Service	17.00	1,098,838	0	1,098,838	31,986.00	34.35	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet S-3
Part III
Date/Time Prepared:
5/24/2019 2:49 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on 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)	48,094,184	0	48,094,184	1,578,019.00	30.48	1.00
2.00	Excluded area salaries (see instructions)	4,099,181	26,548	4,125,729	178,634.00	23.10	2.00
3.00	Subtotal salaries (line 1 minus line 2)	43,995,003	-26,548	43,968,455	1,399,385.00	31.42	3.00
4.00	Subtotal other wages & related costs (see inst.)	9,720,634	0	9,720,634	201,145.00	48.33	4.00
5.00	Subtotal wage-related costs (see inst.)	13,426,965	0	13,426,965	0.00	30.54	5.00
6.00	Total (sum of lines 3 thru 5)	67,142,602	-26,548	67,116,054	1,600,530.00	41.93	6.00
7.00	Total overhead cost (see instructions)	14,795,191	0	14,795,191	469,392.00	31.52	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet S-3
Part IV
Date/Time Prepared:
5/24/2019 2:49 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	1,562,451	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	1,195,377	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)	5,005,312	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	216,766	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	31,657	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)	729,100	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	528,242	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	3,199,643	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	50,917	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	153,410	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	12,672,875	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet S-3
Part V
Date/Time Prepared:
5/24/2019 2:49 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	606,537	12,672,875	1.00
2.00	Hospital	606,537	12,672,875	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018

Worksheet S-10

Date/Time Prepared:
5/24/2019 2:49 pm

			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.233377	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		12,686,084	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		4,720,578	5.00
6.00	Medicaid charges		78,684,388	6.00
7.00	Medicaid cost (line 1 times line 6)		18,363,126	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		956,464	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		956,464	19.00
			Uninsured patients	Insured patients
			1.00	2.00
			Total (col. 1 + col. 2)	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	6,672,511	1,388,475	8,060,986
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,557,211	1,388,475	2,945,686
22.00	Payments received from patients for amounts previously written off as charity care	39,528	53,629	93,157
23.00	Cost of charity care (line 21 minus line 22)	1,517,683	1,334,846	2,852,529
			1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		6,941,542	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		944,286	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		1,452,749	27.01
28.00	Non-Medicare bad debt expense (see instructions)		5,488,793	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		1,789,421	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		4,641,950	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		5,598,414	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018

Worksheet A

Date/Time Prepared:
5/24/2019 2:49 pm

	Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		0	0	4,672,629	4,672,629	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	6,511,392	6,511,392	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	411,683	698,160	1,109,843	-2,364	1,107,479	4.00
4.03	00401	ADMITTING	1,120,632	382,746	1,503,378	-7,936	1,495,442	4.03
5.00	00500	ADMINISTRATIVE & GENERAL	2,992,452	36,558,160	39,550,612	-8,457,404	31,093,208	5.00
7.00	00700	OPERATION OF PLANT	847,485	2,629,097	3,476,582	-53,368	3,423,214	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	368,092	368,092	-262	367,830	8.00
9.00	00900	HOUSEKEEPING	1,091,412	541,489	1,632,901	-5,453	1,627,448	9.00
10.00	01000	DIETARY	0	2,666,125	2,666,125	-24,613	2,641,512	10.00
11.00	01100	CAFETERIA	0	195	195	0	195	11.00
13.00	01300	NURSING ADMINISTRATION	957,605	381,937	1,339,542	-49,106	1,290,436	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	241,187	231,035	472,222	-161,083	311,139	14.00
15.00	01500	PHARMACY	1,860,530	10,092,622	11,953,152	-306,009	11,647,143	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	158,243	104,244	262,487	-1,385	261,102	16.00
17.00	01700	SOCIAL SERVICE	1,098,838	545,719	1,644,557	-2,542	1,642,015	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,929,245	6,460,058	16,389,303	-455,104	15,934,199	30.00
31.00	03100	INTENSIVE CARE UNIT	2,106,858	1,073,313	3,180,171	-105,292	3,074,879	31.00
40.00	04000	SUBPROVIDER - IPF	1,201,317	412,073	1,613,390	-7,917	1,605,473	40.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,780,131	11,652,303	14,432,434	-7,841,248	6,591,186	50.00
51.00	05100	RECOVERY ROOM	517,268	396,896	914,164	-137,738	776,426	51.00
53.00	05300	ANESTHESIOLOGY	33,547	252,119	285,666	-30,629	255,037	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,297,147	1,921,655	4,218,802	-813,936	3,404,866	54.00
56.00	05600	RADIOISOTOPE	196,842	251,483	448,325	298	448,623	56.00
57.00	05700	CT SCAN	241,063	533,731	774,794	-215,477	559,317	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	471,478	922,953	1,394,431	-83,266	1,311,165	58.00
59.00	05900	CARDIAC CATHETERIZATION	603,925	2,357,269	2,961,194	-2,077,913	883,281	59.00
60.00	06000	LABORATORY	1,320,888	2,656,162	3,977,050	-318,298	3,658,752	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	222,079	613,985	836,064	265,617	1,101,681	63.00
65.00	06500	RESPIRATORY THERAPY	949,267	478,269	1,427,536	-84,813	1,342,723	65.00
66.00	06600	PHYSICAL THERAPY	1,202,197	403,144	1,605,341	-64,810	1,540,531	66.00
67.00	06700	OCCUPATIONAL THERAPY	271,511	71,724	343,235	14,166	357,401	67.00
68.00	06800	SPEECH PATHOLOGY	212,221	49,572	261,793	14,889	276,682	68.00
69.00	06900	ELECTROCARDIOLOGY	872,452	551,211	1,423,663	2,316	1,425,979	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,296,335	3,296,335	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	7,411,435	7,411,435	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	362,842	362,842	-11,913	350,929	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	919,060	1,474,931	2,393,991	-87,429	2,306,562	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	788,076	732,534	1,520,610	-162,023	1,358,587	76.01
76.02	03550	OP PSYCH	371,093	146,047	517,140	-11,967	505,173	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	155,791	155,791	76.98
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	3,035,623	1,481,467	4,517,090	-317,808	4,199,282	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	2,013,935	1,565,679	3,579,614	-443,274	3,136,340	95.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	43,337,290	92,021,041	135,358,331	2,488	135,360,819	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	30,513	593,210	623,723	-567	623,156	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	8,965	2,888	11,853	-228	11,625	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	171,985	845,572	1,017,557	-904	1,016,653	193.01
193.02	19302	MEDICAL OFFICE BUILDING	265,156	507,938	773,094	0	773,094	193.02
193.03	19303	HOME CARE PHARMACY	293,337	1,093,973	1,387,310	-789	1,386,521	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	0	0	0	193.05
193.06	19306	VACANT SPACE	0	0	0	0	0	193.06
193.07	19307	POB 2	113,973	486,349	600,322	0	600,322	193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	0	0	0	193.08
193.09	19309	COFFEE BAR	0	47,665	47,665	0	47,665	193.09
200.00		TOTAL (SUM OF LINES 118 through 199)	44,221,219	95,598,636	139,819,855	0	139,819,855	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018

Worksheet A

Date/Time Prepared:
5/24/2019 2:49 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	4,672,629	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	6,511,392	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	58,824	1,166,303	4.00
4.03	00401	ADMITTING	0	1,495,442	4.03
5.00	00500	ADMINISTRATIVE & GENERAL	-5,922,710	25,170,498	5.00
7.00	00700	OPERATION OF PLANT	-23,451	3,399,763	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	367,830	8.00
9.00	00900	HOUSEKEEPING	0	1,627,448	9.00
10.00	01000	DIETARY	495,964	3,137,476	10.00
11.00	01100	CAFETERIA	-502,683	-502,488	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,290,436	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	311,139	14.00
15.00	01500	PHARMACY	0	11,647,143	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,483	258,619	16.00
17.00	01700	SOCIAL SERVICE	0	1,642,015	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,033,629	13,900,570	30.00
31.00	03100	INTENSIVE CARE UNIT	-241,992	2,832,887	31.00
40.00	04000	SUBPROVIDER - IPF	-54,000	1,551,473	40.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	529,731	7,120,917	50.00
51.00	05100	RECOVERY ROOM	0	776,426	51.00
53.00	05300	ANESTHESIOLOGY	0	255,037	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,404,866	54.00
56.00	05600	RADIOISOTOPE	0	448,623	56.00
57.00	05700	CT SCAN	0	559,317	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-632,229	678,936	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	883,281	59.00
60.00	06000	LABORATORY	287,785	3,946,537	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,101,681	63.00
65.00	06500	RESPIRATORY THERAPY	-378	1,342,345	65.00
66.00	06600	PHYSICAL THERAPY	0	1,540,531	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	357,401	67.00
68.00	06800	SPEECH PATHOLOGY	0	276,682	68.00
69.00	06900	ELECTROCARDIOLOGY	-706	1,425,273	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,296,335	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	7,411,435	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	350,929	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	-1,028,536	1,278,026	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	1,358,587	76.01
76.02	03550	OP PSYCH	-57	505,116	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	155,791	76.98
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-11,768	4,187,514	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-36,741	3,099,599	95.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-9,119,059	126,241,760	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	623,156	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	192.01
193.00	19300	NONPAID WORKERS	0	11,625	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	0	1,016,653	193.01
193.02	19302	MEDICAL OFFICE BUILDING	0	773,094	193.02
193.03	19303	HOME CARE PHARMACY	0	1,386,521	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	193.05
193.06	19306	VACANT SPACE	0	0	193.06
193.07	19307	POB 2	0	600,322	193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	193.08
193.09	19309	COFFEE BAR	0	47,665	193.09
200.00		TOTAL (SUM OF LINES 118 through 199)	-9,119,059	130,700,796	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet Non-CMS W
Date/Time Prepared:
5/24/2019 2:49 pm

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAPITAL RELATED COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
4.03	ADMITTING	00401		4.03
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
40.00	SUBPROVIDER - IPF	04000		40.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
56.00	RADIOISOTOPE	05600		56.00
57.00	CT SCAN	05700		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	05800		58.00
59.00	CARDIAC CATHETERIZATION	05900		59.00
60.00	LABORATORY	06000		60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	06300		63.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
74.00	RENAL DIALYSIS	07400		74.00
76.00	ONCOLOGY & PAIN MANAGEMENT	03020	ACUPUNCTURE	76.00
76.01	GASTRO INTESTINAL SERVICES	03340	GASTRO INTESTINAL SERVICES	76.01
76.02	OP PSYCH	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.02
76.98	HYPERBARIC OXYGEN THERAPY	07698		76.98
OUTPATIENT SERVICE COST CENTERS				
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	09500		95.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1 through 117)			118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
192.01	TWIN RIVERS MRI	19201		192.01
193.00	NONPAID WORKERS	19300		193.00
193.01	PHYSICIAN/PUBLIC RELATIONS	19301		193.01
193.02	MEDICAL OFFICE BUILDING	19302		193.02
193.03	HOME CARE PHARMACY	19303		193.03
193.04	MANAGEMENT SERVICES	19304		193.04
193.05	EUNICE SMITH NURSING HOME	19305		193.05
193.06	VACANT SPACE	19306		193.06
193.07	POB 2	19307		193.07
193.08	NON REIMBURSABLE MEALS	19308		193.08
193.09	COFFEE BAR	19309		193.09
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

RECLASSIFICATIONS

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet A-6
Date/Time Prepared:
5/24/2019 2:49 pm

Increases					
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
A - RECLASS DEPRECIATION					
1.00 NEW CAP REL COSTS-BLDG & FIXT	1.00	0	4,550,371		1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	6,459,110		2.00
0		0	11,009,481		
B - RECLASS MEDICAL SUPPLIES					
1.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	10,707,770		1.00
2.00	0.00	0	0		2.00
3.00	0.00	0	0		3.00
4.00	0.00	0	0		4.00
5.00	0.00	0	0		5.00
6.00	0.00	0	0		6.00
7.00	0.00	0	0		7.00
8.00	0.00	0	0		8.00
9.00	0.00	0	0		9.00
10.00	0.00	0	0		10.00
11.00	0.00	0	0		11.00
12.00	0.00	0	0		12.00
13.00	0.00	0	0		13.00
14.00	0.00	0	0		14.00
15.00	0.00	0	0		15.00
16.00	0.00	0	0		16.00
17.00	0.00	0	0		17.00
18.00	0.00	0	0		18.00
19.00	0.00	0	0		19.00
20.00	0.00	0	0		20.00
21.00	0.00	0	0		21.00
22.00	0.00	0	0		22.00
23.00	0.00	0	0		23.00
24.00	0.00	0	0		24.00
0		0	10,707,770		
C - TO RECLASS LAB ADMIN					
1.00 BLOOD STORING, PROCESSING & TRANS.	63.00	87,750	183,935		1.00
0		87,750	183,935		
D - TO RECLASS DIRECTOR'S EXPENSE					
1.00 RECOVERY ROOM	51.00	17,674	1,352		1.00
2.00 ANESTHESIOLOGY	53.00	29,739	2,275		2.00
3.00 RADIOISOTOPE	56.00	2,297	176		3.00
4.00 OCCUPATIONAL THERAPY	67.00	17,626	1,348		4.00
5.00 SPEECH PATHOLOGY	68.00	13,831	1,058		5.00
6.00 ELECTROCARDIOLOGY	69.00	102,378	7,833		6.00
7.00 CT SCAN	57.00	38,501	2,946		7.00
8.00 GASTRO INTESTINAL SERVICES	76.01	21,860	1,673		8.00
9.00 AMBULANCE SERVICES	95.00	26,548	2,031		9.00
10.00 MAGNETIC RESONANCE IMAGING (MRI)	58.00	10,654	815		10.00
0		281,108	21,507		
E - TO RECLASS HYPERBARIC OXYGEN EXPENSE					
1.00 HYPERBARIC OXYGEN THERAPY	76.98	0	155,791		1.00
0		0	155,791		
F - TO RECLASS DEPRECIATION DEPT EXPENSE					
1.00 ADMINISTRATIVE & GENERAL	5.00	0	2,726,617		1.00
2.00	0.00	0	0		2.00
3.00	0.00	0	0		3.00
4.00	0.00	0	0		4.00
5.00	0.00	0	0		5.00
6.00	0.00	0	0		6.00
7.00	0.00	0	0		7.00
8.00	0.00	0	0		8.00
9.00	0.00	0	0		9.00
10.00	0.00	0	0		10.00
11.00	0.00	0	0		11.00
12.00	0.00	0	0		12.00
13.00	0.00	0	0		13.00
14.00	0.00	0	0		14.00
15.00	0.00	0	0		15.00
16.00	0.00	0	0		16.00
17.00	0.00	0	0		17.00
18.00	0.00	0	0		18.00
19.00	0.00	0	0		19.00
20.00	0.00	0	0		20.00

RECLASSIFICATIONS

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018

Worksheet A-6

Date/Time Prepared:
5/24/2019 2:49 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00
34.00		0.00	0	0		34.00
35.00		0.00	0	0		35.00
36.00		0.00	0	0		36.00
37.00		0.00	0	0		37.00
			0	2,726,617		
	G - TO RECLASS PROPERTY INSURANCE					
1.00	OTHER CAPITAL RELATED COSTS	3.00	0	174,540		1.00
			0	174,540		
	H - TO RECLASS MEDICAL IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	7,411,435		1.00
			0	7,411,435		
500.00	Grand Total: Increases		368,858	32,391,076		500.00

RECLASSIFICATIONS

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet A-6
Date/Time Prepared:
5/24/2019 2:49 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS DEPRECIATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	11,009,481	9		1.00
2.00		0.00	0	0	9		2.00
	0		0	11,009,481			
	B - RECLASS MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	119,467	0		1.00
2.00	PHARMACY	15.00	0	302,131	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	332,739	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	82,493	0		4.00
5.00	SUBPROVIDER - IPF	40.00	0	7,621	0		5.00
6.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	1,061	0		6.00
7.00	OPERATING ROOM	50.00	0	7,307,719	0		7.00
8.00	RECOVERY ROOM	51.00	0	135,560	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	48,709	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	23,203	0		10.00
11.00	RADIOISOTOPE	56.00	0	1,098	0		11.00
12.00	CT SCAN	57.00	0	9,145	0		12.00
13.00	CARDIAC CATHETERIZATION	59.00	0	1,920,993	0		13.00
14.00	LABORATORY	60.00	0	978	0		14.00
15.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	272	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	1,625	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	7,605	0		17.00
18.00	OCCUPATIONAL THERAPY	67.00	0	2,039	0		18.00
19.00	ELECTROCARDIOLOGY	69.00	0	5,076	0		19.00
20.00	RENAL DIALYSIS	74.00	0	11,913	0		20.00
21.00	ONCOLOGY & PAIN MANAGEMENT	76.00	0	29,281	0		21.00
22.00	GASTRO INTESTINAL SERVICES	76.01	0	60,065	0		22.00
23.00	EMERGENCY	91.00	0	238,546	0		23.00
24.00	AMBULANCE SERVICES	95.00	0	58,431	0		24.00
	0		0	10,707,770			
	C - TO RECLASS LAB ADMIN						
1.00	LABORATORY	60.00	87,750	183,935	0		1.00
	0		87,750	183,935			
	D - TO RECLASS DIRECTOR'S EXPENSE						
1.00	OPERATING ROOM	50.00	69,273	5,300	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	51,452	3,937	0		2.00
3.00	RESPIRATORY THERAPY	65.00	62,209	3,074	0		3.00
4.00	PHYSICAL THERAPY	66.00	40,169	2,406	0		4.00
5.00	CARDIAC CATHETERIZATION	59.00	31,457	4,759	0		5.00
6.00	EMERGENCY	91.00	26,548	2,031	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
10.00		0.00	0	0	0		10.00
	0		281,108	21,507			
	E - TO RECLASS HYPERBARIC OXYGEN EXPENSE						
1.00	OPERATING ROOM	50.00	0	155,791	0		1.00
	0		0	155,791			
	F - TO RECLASS DEPRECIATION DEPT EXPENSE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,364	0		1.00
2.00	ADMITTING	4.03	0	7,936	0		2.00
3.00	OPERATION OF PLANT	7.00	0	53,368	0		3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	262	0		4.00
5.00	HOUSEKEEPING	9.00	0	5,453	0		5.00
6.00	DIETARY	10.00	0	24,613	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	49,106	0		7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	41,616	0		8.00
9.00	PHARMACY	15.00	0	3,878	0		9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	0	1,385	0		10.00
11.00	SOCIAL SERVICE	17.00	0	2,542	0		11.00
12.00	ADULTS & PEDIATRICS	30.00	0	122,365	0		12.00
13.00	INTENSIVE CARE UNIT	31.00	0	22,799	0		13.00
14.00	SUBPROVIDER - IPF	40.00	0	296	0		14.00
15.00	OPERATING ROOM	50.00	0	303,165	0		15.00
16.00	RECOVERY ROOM	51.00	0	21,204	0		16.00
17.00	ANESTHESIOLOGY	53.00	0	13,934	0		17.00
18.00	RADIOLOGY-DIAGNOSTIC	54.00	0	735,344	0		18.00
19.00	RADIOISOTOPE	56.00	0	1,077	0		19.00
20.00	CT SCAN	57.00	0	247,779	0		20.00
21.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	93,674	0		21.00
22.00	CARDIAC CATHETERIZATION	59.00	0	120,704	0		22.00

RECLASSIFICATIONS

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018

Worksheet A-6

Date/Time Prepared:
5/24/2019 2:49 pm

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
23.00	LABORATORY	60.00	0	45,635	0	23.00
24.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	5,796	0	24.00
25.00	RESPIRATORY THERAPY	65.00	0	17,905	0	25.00
26.00	PHYSICAL THERAPY	66.00	0	14,630	0	26.00
27.00	OCCUPATIONAL THERAPY	67.00	0	2,769	0	27.00
28.00	ELECTROCARDIOLOGY	69.00	0	102,819	0	28.00
29.00	ONCOLOGY & PAIN MANAGEMENT	76.00	0	58,148	0	29.00
30.00	GASTRO INTESTINAL SERVICES	76.01	0	125,491	0	30.00
31.00	OP PSYCH	76.02	0	11,967	0	31.00
32.00	EMERGENCY	91.00	0	50,683	0	32.00
33.00	AMBULANCE SERVICES	95.00	0	413,422	0	33.00
34.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	567	0	34.00
35.00	NONPAID WORKERS	193.00	0	228	0	35.00
36.00	PHYSICIAN/PUBLIC RELATIONS	193.01	0	904	0	36.00
37.00	HOME CARE PHARMACY	193.03	0	789	0	37.00
	0		0	2,726,617		
G - TO RECLASS PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	174,540	12	1.00
	0		0	174,540		
H - TO RECLASS MEDICAL IMPLANTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	7,411,435	0	1.00
	0		0	7,411,435		
500.00	Grand Total: Decreases		368,858	32,391,076		500.00

RECLASSIFICATIONS

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
5/24/2019 2:49 pm

Increases					Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
A - RECLASS DEPRECIATION									
1.00	NEW CAP REL	1.00	0	4,550,371	ADMINISTRATIVE & GENERAL	5.00	0	11,009,481	1.00
2.00	COSTS-BLDG & FIXT	2.00	0	6,459,110		0.00	0	0	2.00
	NEW CAP REL								
	COSTS-MVBLE EQUIP								
	0		0	11,009,481	0		0	11,009,481	
B - RECLASS MEDICAL SUPPLIES									
1.00	MEDICAL SUPPLIES	71.00	0	10,707,770	CENTRAL SERVICES & SUPPLY	14.00	0	119,467	1.00
	CHARGED TO PATIENTS								
2.00		0.00	0	0	PHARMACY	15.00	0	302,131	2.00
3.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	332,739	3.00
4.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	82,493	4.00
5.00		0.00	0	0	SUBPROVIDER - IPF	40.00	0	7,621	5.00
6.00		0.00	0	0	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	1,061	6.00
7.00		0.00	0	0	OPERATING ROOM	50.00	0	7,307,719	7.00
8.00		0.00	0	0	RECOVERY ROOM	51.00	0	135,560	8.00
9.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	48,709	9.00
10.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	23,203	10.00
11.00		0.00	0	0	RADIOISOTOPE	56.00	0	1,098	11.00
12.00		0.00	0	0	CT SCAN	57.00	0	9,145	12.00
13.00		0.00	0	0	CARDIAC CATHETERIZATION	59.00	0	1,920,993	13.00
14.00		0.00	0	0	LABORATORY	60.00	0	978	14.00
15.00		0.00	0	0	BLOOD STORING, PROCESSING & TRANS.	63.00	0	272	15.00
16.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	1,625	16.00
17.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	7,605	17.00
18.00		0.00	0	0	OCCUPATIONAL THERAPY	67.00	0	2,039	18.00
19.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	5,076	19.00
20.00		0.00	0	0	RENAL DIALYSIS	74.00	0	11,913	20.00
21.00		0.00	0	0	ONCOLOGY & PAIN MANAGEMENT	76.00	0	29,281	21.00
22.00		0.00	0	0	GASTRO INTESTINAL SERVICES	76.01	0	60,065	22.00
23.00		0.00	0	0	EMERGENCY	91.00	0	238,546	23.00
24.00		0.00	0	0	AMBULANCE SERVICES	95.00	0	58,431	24.00
	0		0	10,707,770	0		0	10,707,770	
C - TO RECLASS LAB ADMIN									
1.00	BLOOD STORING, PROCESSING & TRANS.	63.00	87,750	183,935	LABORATORY	60.00	87,750	183,935	1.00
	0		87,750	183,935	0		87,750	183,935	
D - TO RECLASS DIRECTOR'S EXPENSE									
1.00	RECOVERY ROOM	51.00	17,674	1,352	OPERATING ROOM	50.00	69,273	5,300	1.00
2.00	ANESTHESIOLOGY	53.00	29,739	2,275	RADIOLOGY-DIAGNOSTIC	54.00	51,452	3,937	2.00
3.00	RADIOISOTOPE	56.00	2,297	176	RESPIRATORY THERAPY	65.00	62,209	3,074	3.00
4.00	OCCUPATIONAL THERAPY	67.00	17,626	1,348	PHYSICAL THERAPY	66.00	40,169	2,406	4.00
5.00	SPEECH PATHOLOGY	68.00	13,831	1,058	CARDIAC CATHETERIZATION	59.00	31,457	4,759	5.00
6.00	ELECTROCARDIOLOGY	69.00	102,378	7,833	EMERGENCY	91.00	26,548	2,031	6.00
7.00	CT SCAN	57.00	38,501	2,946		0.00	0	0	7.00
8.00	GASTRO INTESTINAL SERVICES	76.01	21,860	1,673		0.00	0	0	8.00
9.00	AMBULANCE SERVICES	95.00	26,548	2,031		0.00	0	0	9.00
10.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	10,654	815		0.00	0	0	10.00
	0		281,108	21,507	0		281,108	21,507	
E - TO RECLASS HYPERBARIC OXYGEN EXPENSE									
1.00	HYPERBARIC OXYGEN THERAPY	76.98	0	155,791	OPERATING ROOM	50.00	0	155,791	1.00
	0		0	155,791	0		0	155,791	
F - TO RECLASS DEPRECIATION DEPT EXPENSE									
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,726,617	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,364	1.00
2.00		0.00	0	0	ADMITTING	4.03	0	7,936	2.00
3.00		0.00	0	0	OPERATION OF PLANT	7.00	0	53,368	3.00
4.00		0.00	0	0	LAUNDRY & LINEN SERVICE	8.00	0	262	4.00
5.00		0.00	0	0	HOUSEKEEPING	9.00	0	5,453	5.00
6.00		0.00	0	0	DIETARY	10.00	0	24,613	6.00
7.00		0.00	0	0	NURSING ADMINISTRATION	13.00	0	49,106	7.00
8.00		0.00	0	0	CENTRAL SERVICES & SUPPLY	14.00	0	41,616	8.00
9.00		0.00	0	0	PHARMACY	15.00	0	3,878	9.00

RECLASSIFICATIONS

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
5/24/2019 2:49 pm

Increases					Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
10.00		0.00	0	0	0 MEDICAL RECORDS & LIBRARY	16.00	0	1,385	10.00
11.00		0.00	0	0	0 SOCIAL SERVICE	17.00	0	2,542	11.00
12.00		0.00	0	0	0 ADULTS & PEDIATRICS	30.00	0	122,365	12.00
13.00		0.00	0	0	0 INTENSIVE CARE UNIT	31.00	0	22,799	13.00
14.00		0.00	0	0	0 SUBPROVIDER - IPF	40.00	0	296	14.00
15.00		0.00	0	0	0 OPERATING ROOM	50.00	0	303,165	15.00
16.00		0.00	0	0	0 RECOVERY ROOM	51.00	0	21,204	16.00
17.00		0.00	0	0	0 ANESTHESIOLOGY	53.00	0	13,934	17.00
18.00		0.00	0	0	0 RADIOLOGY-DIAGNOSTIC	54.00	0	735,344	18.00
19.00		0.00	0	0	0 RADIOISOTOPE	56.00	0	1,077	19.00
20.00		0.00	0	0	0 CT SCAN	57.00	0	247,779	20.00
21.00		0.00	0	0	0 MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	93,674	21.00
22.00		0.00	0	0	0 CARDIAC CATHETERIZATION	59.00	0	120,704	22.00
23.00		0.00	0	0	0 LABORATORY	60.00	0	45,635	23.00
24.00		0.00	0	0	0 BLOOD STORING, PROCESSING & TRANS.	63.00	0	5,796	24.00
25.00		0.00	0	0	0 RESPIRATORY THERAPY	65.00	0	17,905	25.00
26.00		0.00	0	0	0 PHYSICAL THERAPY	66.00	0	14,630	26.00
27.00		0.00	0	0	0 OCCUPATIONAL THERAPY	67.00	0	2,769	27.00
28.00		0.00	0	0	0 ELECTROCARDIOLOGY	69.00	0	102,819	28.00
29.00		0.00	0	0	0 ONCOLOGY & PAIN MANAGEMENT	76.00	0	58,148	29.00
30.00		0.00	0	0	0 GASTRO INTESTINAL SERVICES	76.01	0	125,491	30.00
31.00		0.00	0	0	0 OP PSYCH	76.02	0	11,967	31.00
32.00		0.00	0	0	0 EMERGENCY	91.00	0	50,683	32.00
33.00		0.00	0	0	0 AMBULANCE SERVICES	95.00	0	413,422	33.00
34.00		0.00	0	0	0 GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	567	34.00
35.00		0.00	0	0	0 NONPAID WORKERS	193.00	0	228	35.00
36.00		0.00	0	0	0 PHYSICIAN/PUBLIC RELATIONS	193.01	0	904	36.00
37.00		0.00	0	0	0 HOME CARE PHARMACY	193.03	0	789	37.00
			0	2,726,617	0		0	2,726,617	
G - TO RECLASS PROPERTY INSURANCE									
1.00	OTHER CAPITAL RELATED COSTS	3.00	0	174,540	ADMINISTRATIVE & GENERAL	5.00	0	174,540	1.00
			0	174,540			0	174,540	
H - TO RECLASS MEDICAL IMPLANTS									
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	7,411,435	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	7,411,435	1.00
			0	7,411,435			0	7,411,435	
500.00	Grand Total: Increases		368,858	32,391,076	Grand Total: Decreases		368,858	32,391,076	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet A-7
Part I
Date/Time Prepared:
5/24/2019 2:49 pm

		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	177,168	0	0	0	0	1.00	
2.00	Land Improvements	6,130,186	1,627	0	1,627	1,029,242	2.00	
3.00	Buildings and Fixtures	67,206,065	141,588	0	141,588	0	3.00	
4.00	Building Improvements	17,587,153	888,053	0	888,053	3,903,511	4.00	
5.00	Fixed Equipment	39,661,369	948,134	0	948,134	3,463,135	5.00	
6.00	Movable Equipment	59,188,735	5,560,032	0	5,560,032	13,563,820	6.00	
7.00	HIT designated Assets	6,035,516	0	0	0	4,046,096	7.00	
8.00	Subtotal (sum of lines 1-7)	195,986,192	7,539,434	0	7,539,434	26,005,804	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	195,986,192	7,539,434	0	7,539,434	26,005,804	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	177,168	0				1.00	
2.00	Land Improvements	5,102,571	0				2.00	
3.00	Buildings and Fixtures	67,347,653	0				3.00	
4.00	Building Improvements	14,571,695	0				4.00	
5.00	Fixed Equipment	37,146,368	0				5.00	
6.00	Movable Equipment	51,184,947	0				6.00	
7.00	HIT designated Assets	1,989,420	0				7.00	
8.00	Subtotal (sum of lines 1-7)	177,519,822	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	177,519,822	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet A-7
Part II
Date/Time Prepared:
5/24/2019 2:49 pm

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet A-7
Part III
Date/Time Prepared:
5/24/2019 2:49 pm

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	NEW CAP REL COSTS-BLDG & FIXT	124,345,455	0	124,345,455	0.700460	122,258	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	53,174,367	0	53,174,367	0.299540	52,282	2.00
3.00	Total (sum of lines 1-2)	177,519,822	0	177,519,822	1.000000	174,540	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	122,258	4,550,371	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	52,282	6,459,110	0	2.00
3.00	Total (sum of lines 1-2)	0	0	174,540	11,009,481	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	122,258	0	0	4,672,629	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	52,282	0	0	6,511,392	2.00
3.00	Total (sum of lines 1-2)	0	174,540	0	0	11,184,021	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018

Worksheet A-8

Date/Time Prepared:
5/24/2019 2:49 pm

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	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0 NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			0 NEW 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)	A	-463	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,771,447			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	-2,599,194			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-499,086	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0 RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0 PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0 *** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0 NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			0 NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0 *** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0 OCCUPATIONAL THERAPY	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 SPEECH PATHOLOGY	68.00		31.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018

Worksheet A-8

Date/Time Prepared:
5/24/2019 2:49 pm

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted					
Cost Center Description			Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7	Ref.
			1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00	ASSOCIATION DUES	A		-31,745	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	OTHER REVENUE -MRI	A		-2,229	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	33.01
33.02	ELIMINATE FINANCING COSTS	A		-3,097	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	NON OPERATING DONATIONS	B		-8,095	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	OTHER NON OPERATING REVENUE	B		-209,619	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	MALPRACTICE EXPENSE	A		-1,297,000	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	ESH DIETARY COSTS	A		512,226	DIETARY	10.00	0	33.06
33.07	OTHER REVENUE - A&G	B		-786,534	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	OTHER REVENUE - PLANT OPERATIONS	B		-22,988	OPERATION OF PLANT	7.00	0	33.08
33.09	OTHER REVENUE - CAFETERIA	B		-3,597	CAFETERIA	11.00	0	33.09
33.10	OTHER REVENUE - MEDICAL RECORDS	B		-2,483	MEDICAL RECORDS & LIBRARY	16.00	0	33.10
33.11	OTHER REVENUE EMERGENCY ROOM	B		-11,768	EMERGENCY	91.00	0	33.11
33.12	OTHER REVENUE - DIETARY	B		-16,262	DIETARY	10.00	0	33.12
33.13	OTHER REVENUE - ONCOLOGY	B		-3,136	ONCOLOGY & PAIN MANAGEMENT	76.00	0	33.13
33.14	OTHER REVENUE - EKG	B		-706	ELECTROCARDIOLOGY	69.00	0	33.14
33.15	OTHER REVENUE - AMBULANCE	A		-36,741	AMBULANCE SERVICES	95.00	0	33.15
33.16	ABESTOS ABATEMENT	A		-24,510	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	PENSION EXPENSE	A		70,580	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.17
33.19	DISALLOWED INTEREST EXPENSE	A		-338,888	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	ALCOHOLIC BEVERAGES	A		-2,803	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21	ALCOHOLIC BEVERAGES	A		-8	ADULTS & PEDIATRICS	30.00	0	33.21
33.22	ALCOHOLIC BEVERAGES	A		-13	LABORATORY	60.00	0	33.22
33.23	ALCOHOLIC BEVERAGES	A		-60	RESPIRATORY THERAPY	65.00	9	33.23
33.24	ENTERTAINMENT EXPENSE	B		-11,756	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.24
33.25	ENTERTAINMENT EXPENSE	A		-9,710	ADMINISTRATIVE & GENERAL	5.00	0	33.25
33.26	ENTERTAINMENT EXPENSE	B		-318	RESPIRATORY THERAPY	65.00	0	33.26
33.27	ENTERTAINMENT EXPENSE	A		-57	OP PSYCH	76.02	0	33.27
33.28	NON ALLOWABLE EMPLOYEE ACTIVITIES	A		-7,552	ADMINISTRATIVE & GENERAL	5.00	0	33.28
33.29	OTHER ADJUSTMENTS (SPECIFY) (3)			0		0.00	0	33.29
33.30	OTHER ADJUSTMENTS (SPECIFY) (3)			0		0.00	0	33.30
33.31	OTHER ADJUSTMENTS (SPECIFY) (3)			0		0.00	0	33.31
33.32	OTHER ADJUSTMENTS (SPECIFY) (3)			0		0.00	0	33.32
33.33	OTHER ADJUSTMENTS (SPECIFY) (3)			0		0.00	0	33.33
33.34	OTHER ADJUSTMENTS (SPECIFY) (3)			0		0.00	0	33.34
33.35	OTHER ADJUSTMENTS (SPECIFY) (3)			0		0.00	0	33.35
34.00	OTHER ADJUSTMENTS (SPECIFY)			0		0.00	0	34.00
35.00	OTHER ADJUSTMENTS (SPECIFY)			0		0.00	0	35.00
36.00	OTHER ADJUSTMENTS (SPECIFY)			0		0.00	0	36.00
37.00	OTHER ADJUSTMENTS (SPECIFY)			0		0.00	0	37.00
38.00	OTHER ADJUSTMENTS (SPECIFY)			0		0.00	0	38.00
39.00	OTHER ADJUSTMENTS (SPECIFY)			0		0.00	0	39.00
40.00	OTHER ADJUSTMENTS (SPECIFY)			0		0.00	0	40.00
41.00	OTHER ADJUSTMENTS (SPECIFY)			0		0.00	0	41.00
42.00	OTHER ADJUSTMENTS (SPECIFY)			0		0.00	0	42.00
43.00	OTHER ADJUSTMENTS (SPECIFY)			0		0.00	0	43.00
44.00	OTHER ADJUSTMENTS (SPECIFY)			0		0.00	0	44.00
45.00	OTHER ADJUSTMENTS (SPECIFY)			0		0.00	0	45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)			-9,119,059				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: 14-0002

Period:
From 01/01/2018
To 12/31/2018

Worksheet A-8-1

Date/Time Prepared:
5/24/2019 2:49 pm

	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	BJC HEALTH SYSTEM	15,870,421	18,589,203	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	CHRISTIAN HEALTH SERVICES	29,279	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	TELEPHONE FACILITIES CORP	71,380	71,144	3.00
4.00	60.00	LABORATORY	BARNES JEWISH LAB	483,057	283,619	4.00
4.01	60.00	LABORATORY	CHILDREN'S HOSPITAL LAB	232,564	139,056	4.01
4.02	60.00	LABORATORY	MISSOURI BAPTIST HOSPITAL LA	3,632	8,780	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	BJC ACO OPERATIONS	0	197,725	4.03
5.00	0		0	16,690,333	19,289,527	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	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	G	BJC HEALTHCARE	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:	HOME OFFICE				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: 14-0002

Period:
From 01/01/2018
To 12/31/2018

Worksheet A-8-1

Date/Time Prepared:
5/24/2019 2:49 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-2,718,782	0		1.00
2.00	29,279	0		2.00
3.00	236	0		3.00
4.00	199,438	0		4.00
4.01	93,508	0		4.01
4.02	-5,148	0		4.02
4.03	-197,725	0		4.03
5.00	-2,599,194			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: 14-0002

Period:
From 01/01/2018
To 12/31/2018

Worksheet A-8-2

Date/Time Prepared:
5/24/2019 2:49 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	1,903,807	1,903,807	0	0	0	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	129,814	129,814	0	0	0	2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	241,992	241,992	0	0	0	3.00
4.00	40.00	AGGREGATE-SUBPROVIDER - IPF	54,000	54,000	0	0	0	4.00
5.00	50.00	AGGREGATE-OPERATING ROOM	-529,731	-529,731	0	0	0	5.00
6.00	58.00	AGGREGATE-MAGNETIC RESONANCE IMAGING	630,000	630,000	0	0	0	6.00
7.00	76.00	AGGREGATE-ONCOLOGY & PAIN MANAGEMENT	1,025,400	1,025,400	0	0	0	7.00
8.00	5.00	DR. A	8,250	0	8,250	211,500	14	8.00
9.00	5.00	DR. B	1,800	0	1,800	237,100	13	9.00
10.00	5.00	DR. C	2,205	0	2,205	211,500	11	10.00
11.00	5.00	DR. D	1,896	0	1,896	211,500	11	11.00
12.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	307,156	307,156	0	0	0	12.00
200.00			3,776,589	3,762,438	14,151		49	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	0	0	4.00
5.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	5.00
6.00	58.00	AGGREGATE-MAGNETIC RESONANCE IMAGING	0	0	0	0	0	6.00
7.00	76.00	AGGREGATE-ONCOLOGY & PAIN MANAGEMENT	0	0	0	0	0	7.00
8.00	5.00	DR. A	1,424	71	0	0	0	8.00
9.00	5.00	DR. B	1,482	74	0	0	0	9.00
10.00	5.00	DR. C	1,118	56	0	0	0	10.00
11.00	5.00	DR. D	1,118	56	0	0	0	11.00
12.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	0	0	12.00
200.00			5,142	257	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	1,903,807		1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	129,814		2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	241,992		3.00
4.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	54,000		4.00
5.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	-529,731		5.00
6.00	58.00	AGGREGATE-MAGNETIC RESONANCE IMAGING	0	0	0	630,000		6.00
7.00	76.00	AGGREGATE-ONCOLOGY & PAIN MANAGEMENT	0	0	0	1,025,400		7.00
8.00	5.00	DR. A	0	1,424	6,826	6,826		8.00
9.00	5.00	DR. B	0	1,482	318	318		9.00
10.00	5.00	DR. C	0	1,118	1,087	1,087		10.00
11.00	5.00	DR. D	0	1,118	778	778		11.00
12.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	307,156		12.00
200.00			0	5,142	9,009	3,771,447		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet B
Part I
Date/Time Prepared:
5/24/2019 2:49 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00	2.00	4.00	4.03	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	4,672,629	4,672,629			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	6,511,392	6,511,392			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,166,303	25,451	2,383	1,194,137	4.00
4.03	00401	ADMITTING	1,495,442	56,168	8,000	30,545	4.03
5.00	00500	ADMINISTRATIVE & GENERAL	25,170,498	263,261	4,066,151	81,565	5.00
7.00	00700	OPERATION OF PLANT	3,399,763	1,817,832	27,328	23,100	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	367,830	11,380	264	0	8.00
9.00	00900	HOUSEKEEPING	1,627,448	26,910	5,497	29,749	9.00
10.00	01000	DIETARY	3,137,476	111,684	18,405	0	10.00
11.00	01100	CAFETERIA	-502,488	48,295	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,290,436	5,121	38,069	26,101	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	311,139	46,101	38,738	6,574	14.00
15.00	01500	PHARMACY	11,647,143	28,658	3,909	50,712	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	258,619	54,947	1,396	4,313	16.00
17.00	01700	SOCIAL SERVICE	1,642,015	5,421	2,562	29,951	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	13,900,570	567,709	121,158	270,664	30.00
31.00	03100	INTENSIVE CARE UNIT	2,832,887	56,778	22,982	57,427	31.00
40.00	04000	SUBPROVIDER - IPF	1,551,473	76,021	298	32,744	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,120,917	214,211	290,803	73,890	50.00
51.00	05100	RECOVERY ROOM	776,426	34,979	21,374	14,581	51.00
53.00	05300	ANESTHESIOLOGY	255,037	2,524	14,046	1,725	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,404,866	112,967	741,231	61,211	54.00
56.00	05600	RADIOISOTOPE	448,623	10,356	1,086	5,428	56.00
57.00	05700	CT SCAN	559,317	5,887	162,424	7,620	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	678,936	49,733	1,730	13,141	58.00
59.00	05900	CARDIAC CATHETERIZATION	883,281	18,219	121,670	14,766	59.00
60.00	06000	LABORATORY	3,946,537	148,784	46,000	33,612	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,101,681	3,766	5,842	8,445	63.00
65.00	06500	RESPIRATORY THERAPY	1,342,345	15,953	18,048	24,779	65.00
66.00	06600	PHYSICAL THERAPY	1,540,531	56,126	14,747	31,911	66.00
67.00	06700	OCCUPATIONAL THERAPY	357,401	15,115	2,791	7,881	67.00
68.00	06800	SPEECH PATHOLOGY	276,682	5,173	0	6,161	68.00
69.00	06900	ELECTROCARDIOLOGY	1,425,273	52,267	86,515	26,571	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,296,335	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	7,411,435	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	350,929	2,897	0	0	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	1,278,026	18,385	39,326	25,051	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	1,358,587	35,404	126,496	22,076	76.01
76.02	03550	OP PSYCH	505,116	40,163	12,063	10,115	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	155,791	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	4,187,514	172,010	28,820	82,018	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	3,099,599	10,098	416,732	55,617	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	126,241,760	4,226,754	6,508,884	1,170,044	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	623,156	10,718	572	832	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	11,625	16,512	230	244	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	1,016,653	10,770	911	4,688	193.01
193.02	19302	MEDICAL OFFICE BUILDING	773,094	0	0	7,227	193.02
193.03	19303	HOME CARE PHARMACY	1,386,521	4,976	795	7,995	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	0	0	193.05
193.06	19306	VACANT SPACE	0	401,016	0	0	193.06
193.07	19307	POB 2	600,322	0	0	3,107	193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	0	0	193.08
193.09	19309	COFFEE BAR	47,665	1,883	0	0	193.09
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	130,700,796	4,672,629	6,511,392	1,194,137	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet B
Part I
Date/Time Prepared:
5/24/2019 2:49 pm

Cost Center Description			Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4A.03	5.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.03	00401	ADMITTING						4.03
5.00	00500	ADMINISTRATIVE & GENERAL	29,581,475	29,581,475				5.00
7.00	00700	OPERATION OF PLANT	5,268,023	1,534,217	6,802,240			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	379,474	110,515	30,843	520,832		8.00
9.00	00900	HOUSEKEEPING	1,689,604	492,067	72,929	0	2,254,600	9.00
10.00	01000	DIETARY	3,267,565	951,619	302,679	0	101,877	10.00
11.00	01100	CAFETERIA	-454,193	0	130,885	0	44,054	11.00
13.00	01300	NURSING ADMINISTRATION	1,359,727	395,996	13,879	0	4,672	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	402,552	117,236	124,941	5,765	42,053	14.00
15.00	01500	PHARMACY	11,730,422	3,416,274	77,667	493	26,142	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	319,275	92,983	148,914	0	50,122	16.00
17.00	01700	SOCIAL SERVICE	1,679,949	489,255	14,692	0	4,945	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,016,660	4,373,354	1,538,574	185,186	517,858	30.00
31.00	03100	INTENSIVE CARE UNIT	3,000,539	873,853	153,877	35,922	51,793	31.00
40.00	04000	SUBPROVIDER - IPF	1,677,523	488,548	206,029	11,486	69,346	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,820,452	2,277,566	580,543	69,496	195,402	50.00
51.00	05100	RECOVERY ROOM	867,541	252,656	94,799	11,181	31,908	51.00
53.00	05300	ANESTHESIOLOGY	307,289	89,492	6,841	0	2,303	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,444,593	1,294,408	306,156	26,516	103,047	54.00
56.00	05600	RADIOISOTOPE	474,065	138,063	28,067	1,989	9,447	56.00
57.00	05700	CT SCAN	878,905	255,965	15,954	13,268	5,370	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	783,291	228,119	134,782	1,882	45,366	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,065,935	310,434	49,376	10,815	16,619	59.00
60.00	06000	LABORATORY	4,325,270	1,259,657	403,226	0	135,720	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,136,116	330,873	10,206	0	3,435	63.00
65.00	06500	RESPIRATORY THERAPY	1,419,837	413,502	43,236	0	14,553	65.00
66.00	06600	PHYSICAL THERAPY	1,668,290	485,859	152,110	9,118	51,198	66.00
67.00	06700	OCCUPATIONAL THERAPY	387,820	112,946	40,965	0	13,788	67.00
68.00	06800	SPEECH PATHOLOGY	291,651	84,938	14,019	0	4,719	68.00
69.00	06900	ELECTROCARDIOLOGY	1,672,014	486,944	141,652	304	47,678	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,336,345	971,650	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	7,490,734	2,181,541	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	103,936	30,269	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	356,919	103,946	7,851	0	2,642	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	1,381,820	402,430	49,825	0	16,770	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	1,567,524	456,513	95,949	22,600	32,295	76.01
76.02	03550	OP PSYCH	573,240	166,946	108,847	46	36,636	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	161,879	47,144	0	1,491	0	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	4,698,840	1,368,453	466,173	90,193	156,907	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	3,636,383	1,059,031	27,366	23,081	9,211	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	125,769,284	28,145,262	5,593,852	520,832	1,847,876	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	635,278	185,013	29,048	0	9,777	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	28,611	8,332	44,750	0	15,062	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	1,033,022	300,849	29,188	0	9,824	193.01
193.02	19302	MEDICAL OFFICE BUILDING	780,321	227,254	0	0	0	193.02
193.03	19303	HOME CARE PHARMACY	1,400,287	407,808	13,487	0	4,539	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	0	0	0	193.05
193.06	19306	VACANT SPACE	401,016	116,789	1,086,812	0	365,804	193.06
193.07	19307	POB 2	603,429	175,738	0	0	0	193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	0	0	0	193.08
193.09	19309	COFFEE BAR	49,548	14,430	5,103	0	1,718	193.09
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	130,700,796	29,581,475	6,802,240	520,832	2,254,600	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet B
Part I
Date/Time Prepared:
5/24/2019 2:49 pm

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.03	00401	ADMITTING						4.03
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	4,623,740					10.00
11.00	01100	CAFETERIA	2,399,738	2,120,484				11.00
13.00	01300	NURSING ADMINISTRATION	0	36,444	1,810,718			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	20,706	0	713,253		14.00
15.00	01500	PHARMACY	0	74,664	0	0	15,325,662	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	15,629	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	55,482	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	767,364	557,646	1,284,207	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	88,118	96,422	222,071	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	103,494	57,911	133,418	0	0	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	140,408	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	22,628	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	4,895	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	123,945	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	7,470	0	0	0	56.00
57.00	05700	CT SCAN	0	14,940	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	26,870	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	27,378	0	0	0	59.00
60.00	06000	LABORATORY	0	101,752	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	18,566	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	48,592	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	56,461	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	14,070	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	8,703	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	52,834	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	219,572	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	493,681	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	15,325,662	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0	55,191	83,473	0	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	38,837	87,549	0	0	76.01
76.02	03550	OP PSYCH	0	24,151	0	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	163,616	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	187,187	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,358,714	2,053,398	1,810,718	713,253	15,325,662	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,590	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	1,197	0	0	0	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	0	7,252	0	0	0	193.01
193.02	19302	MEDICAL OFFICE BUILDING	0	24,949	0	0	0	193.02
193.03	19303	HOME CARE PHARMACY	0	16,681	0	0	0	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	975,825	0	0	0	0	193.05
193.06	19306	VACANT SPACE	0	0	0	0	0	193.06
193.07	19307	POB 2	0	13,417	0	0	0	193.07
193.08	19308	NON REIMBURSABLE MEALS	289,201	0	0	0	0	193.08
193.09	19309	COFFEE BAR	0	0	0	0	0	193.09
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)	4,623,740	2,120,484	1,810,718	713,253	15,325,662	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet B
Part I
Date/Time Prepared:
5/24/2019 2:49 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.03	00401	ADMITTING						4.03
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
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	626,923					16.00
17.00	01700	SOCIAL SERVICE	0	2,244,323				17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	61,712	1,822,064	26,124,625	0	26,124,625	30.00
31.00	03100	INTENSIVE CARE UNIT	12,009	194,187	4,728,791	0	4,728,791	31.00
40.00	04000	SUBPROVIDER - IPF	6,696	228,072	2,982,523	0	2,982,523	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	47,550	0	11,131,417	0	11,131,417	50.00
51.00	05100	RECOVERY ROOM	7,955	0	1,288,668	0	1,288,668	51.00
53.00	05300	ANESTHESIOLOGY	13,385	0	424,205	0	424,205	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	49,003	0	6,347,668	0	6,347,668	54.00
56.00	05600	RADIOISOTOPE	3,379	0	662,480	0	662,480	56.00
57.00	05700	CT SCAN	56,626	0	1,241,028	0	1,241,028	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	15,669	0	1,235,979	0	1,235,979	58.00
59.00	05900	CARDIAC CATHETERIZATION	11,036	0	1,491,593	0	1,491,593	59.00
60.00	06000	LABORATORY	59,259	0	6,284,884	0	6,284,884	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	6,457	0	1,505,653	0	1,505,653	63.00
65.00	06500	RESPIRATORY THERAPY	7,376	0	1,947,096	0	1,947,096	65.00
66.00	06600	PHYSICAL THERAPY	9,845	0	2,432,881	0	2,432,881	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,826	0	571,415	0	571,415	67.00
68.00	06800	SPEECH PATHOLOGY	1,433	0	405,463	0	405,463	68.00
69.00	06900	ELECTROCARDIOLOGY	32,081	0	2,433,507	0	2,433,507	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,771	0	4,543,338	0	4,543,338	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	31,258	0	10,197,214	0	10,197,214	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	40,969	0	15,500,836	0	15,500,836	73.00
74.00	07400	RENAL DIALYSIS	1,219	0	472,577	0	472,577	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	8,290	0	1,997,799	0	1,997,799	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	9,839	0	2,311,106	0	2,311,106	76.01
76.02	03550	OP PSYCH	2,280	0	912,146	0	912,146	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	2,400	0	212,914	0	212,914	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	90,182	0	7,034,364	0	7,034,364	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	21,418	0	4,963,677	0	4,963,677	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	626,923	2,244,323	121,385,847	0	121,385,847	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	862,706	0	862,706	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	97,952	0	97,952	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	0	0	1,380,135	0	1,380,135	193.01
193.02	19302	MEDICAL OFFICE BUILDING	0	0	1,032,524	0	1,032,524	193.02
193.03	19303	HOME CARE PHARMACY	0	0	1,842,802	0	1,842,802	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	975,825	0	975,825	193.05
193.06	19306	VACANT SPACE	0	0	1,970,421	0	1,970,421	193.06
193.07	19307	POB 2	0	0	792,584	0	792,584	193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	289,201	0	289,201	193.08
193.09	19309	COFFEE BAR	0	0	70,799	0	70,799	193.09
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	626,923	2,244,323	130,700,796	0	130,700,796	202.00

COST ALLOCATION STATISTICS

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018

Worksheet Non-CMS W

Date/Time Prepared:
5/24/2019 2:49 pm

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	5	GROSS SALARIES	4.00
4.03	ADMITTING	7	GROSS REVENUE	4.03
5.00	ADMINISTRATIVE & GENERAL	-21	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	12	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	14	MEALS SERVED	10.00
11.00	CAFETERIA	15	FTE'S	11.00
13.00	NURSING ADMINISTRATION	16	HOURS OF SERVICE	13.00
14.00	CENTRAL SERVICES & SUPPLY	17	COSTED REQUISITIONS	14.00
15.00	PHARMACY	18	COSTED REQUISITIONS	15.00
16.00	MEDICAL RECORDS & LIBRARY	7	GROSS REVENUE	16.00
17.00	SOCIAL SERVICE	20	PATIENT DAYS	17.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet B
Part II
Date/Time Prepared:
5/24/2019 2:49 pm

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,552	25,451	2,383	33,386	4.00
4.03	00401	ADMITTING	5,472	56,168	8,000	69,640	4.03
5.00	00500	ADMINISTRATIVE & GENERAL	637,023	263,261	4,066,151	4,966,435	5.00
7.00	00700	OPERATION OF PLANT	5,250	1,817,832	27,328	1,850,410	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	11,380	264	11,644	8.00
9.00	00900	HOUSEKEEPING	491	26,910	5,497	32,898	9.00
10.00	01000	DIETARY	9,002	111,684	18,405	139,091	10.00
11.00	01100	CAFETERIA	0	48,295	0	48,295	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,121	38,069	43,190	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	432	46,101	38,738	85,271	14.00
15.00	01500	PHARMACY	124,831	28,658	3,909	157,398	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,860	54,947	1,396	60,203	16.00
17.00	01700	SOCIAL SERVICE	2,676	5,421	2,562	10,659	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	384,914	567,709	121,158	1,073,781	30.00
31.00	03100	INTENSIVE CARE UNIT	2,220	56,778	22,982	81,980	31.00
40.00	04000	SUBPROVIDER - IPF	1,752	76,021	298	78,071	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	12,391	214,211	290,803	517,405	50.00
51.00	05100	RECOVERY ROOM	429	34,979	21,374	56,782	51.00
53.00	05300	ANESTHESIOLOGY	0	2,524	14,046	16,570	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,870	112,967	741,231	859,068	54.00
56.00	05600	RADIOISOTOPE	0	10,356	1,086	11,442	56.00
57.00	05700	CT SCAN	0	5,887	162,424	168,311	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,221	49,733	1,730	53,684	58.00
59.00	05900	CARDIAC CATHETERIZATION	399	18,219	121,670	140,288	59.00
60.00	06000	LABORATORY	19,550	148,784	46,000	214,334	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	3,766	5,842	9,608	63.00
65.00	06500	RESPIRATORY THERAPY	41,215	15,953	18,048	75,216	65.00
66.00	06600	PHYSICAL THERAPY	2,902	56,126	14,747	73,775	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	15,115	2,791	17,906	67.00
68.00	06800	SPEECH PATHOLOGY	0	5,173	0	5,173	68.00
69.00	06900	ELECTROCARDIOLOGY	1,953	52,267	86,515	140,735	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	2,897	0	2,897	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	5,731	18,385	39,326	63,442	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	5,433	35,404	126,496	167,333	76.01
76.02	03550	OP PSYCH	3,323	40,163	12,063	55,549	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	3,658	172,010	28,820	204,488	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	-190	10,098	416,732	426,640	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,287,360	4,226,754	6,508,884	12,022,998	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,718	572	11,290	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	16,512	230	16,742	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	563	10,770	911	12,244	193.01
193.02	19302	MEDICAL OFFICE BUILDING	0	0	0	0	193.02
193.03	19303	HOME CARE PHARMACY	558	4,976	795	6,329	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	0	0	193.05
193.06	19306	VACANT SPACE	0	401,016	0	401,016	193.06
193.07	19307	POB 2	0	0	0	0	193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	0	0	193.08
193.09	19309	COFFEE BAR	0	1,883	0	1,883	193.09
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,288,481	4,672,629	6,511,392	12,472,502	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet B
Part II
Date/Time Prepared:
5/24/2019 2:49 pm

Cost Center Description			ADMITTING	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4.03	5.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.03	00401	ADMITTING	70,494					4.03
5.00	00500	ADMINISTRATIVE & GENERAL	0	4,968,715				5.00
7.00	00700	OPERATION OF PLANT	0	257,696	2,108,752			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	18,563	9,561	39,768		8.00
9.00	00900	HOUSEKEEPING	0	82,650	22,609	0	138,989	9.00
10.00	01000	DIETARY	0	159,839	93,833	0	6,280	10.00
11.00	01100	CAFETERIA	0	0	40,575	0	2,716	11.00
13.00	01300	NURSING ADMINISTRATION	0	66,514	4,303	0	288	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	19,692	38,733	440	2,592	14.00
15.00	01500	PHARMACY	0	573,817	24,078	38	1,612	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	15,618	46,165	0	3,090	16.00
17.00	01700	SOCIAL SERVICE	0	82,178	4,555	0	305	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,965	734,615	476,969	14,139	31,921	30.00
31.00	03100	INTENSIVE CARE UNIT	1,355	146,777	47,703	2,743	3,193	31.00
40.00	04000	SUBPROVIDER - IPF	756	82,059	63,871	877	4,275	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,367	382,553	179,973	5,306	12,046	50.00
51.00	05100	RECOVERY ROOM	898	42,438	29,389	854	1,967	51.00
53.00	05300	ANESTHESIOLOGY	1,511	15,032	2,121	0	142	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,531	217,416	94,911	2,025	6,353	54.00
56.00	05600	RADIOISOTOPE	381	23,190	8,701	152	582	56.00
57.00	05700	CT SCAN	6,391	42,993	4,946	1,013	331	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,768	38,316	41,784	144	2,797	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,246	52,142	15,307	826	1,025	59.00
60.00	06000	LABORATORY	6,688	211,579	125,003	0	8,367	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	729	55,575	3,164	0	212	63.00
65.00	06500	RESPIRATORY THERAPY	832	69,454	13,403	0	897	65.00
66.00	06600	PHYSICAL THERAPY	1,111	81,608	47,156	696	3,156	66.00
67.00	06700	OCCUPATIONAL THERAPY	206	18,971	12,699	0	850	67.00
68.00	06800	SPEECH PATHOLOGY	162	14,267	4,346	0	291	68.00
69.00	06900	ELECTROCARDIOLOGY	3,621	81,790	43,913	23	2,939	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,780	163,204	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,528	366,424	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,624	5,084	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	138	17,459	2,434	0	163	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	936	67,594	15,446	0	1,034	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	1,110	76,679	29,745	1,726	1,991	76.01
76.02	03550	OP PSYCH	257	28,041	33,743	3	2,258	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	271	7,919	0	114	0	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	9,915	229,853	144,518	6,887	9,673	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	2,417	177,881	8,484	1,762	568	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	70,494	4,727,480	1,734,141	39,768	113,914	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	31,076	9,005	0	603	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	1,400	13,873	0	929	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	0	50,532	9,049	0	606	193.01
193.02	19302	MEDICAL OFFICE BUILDING	0	38,171	0	0	0	193.02
193.03	19303	HOME CARE PHARMACY	0	68,498	4,181	0	280	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	0	0	0	193.05
193.06	19306	VACANT SPACE	0	19,616	336,921	0	22,551	193.06
193.07	19307	POB 2	0	29,518	0	0	0	193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	0	0	0	193.08
193.09	19309	COFFEE BAR	0	2,424	1,582	0	106	193.09
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)	70,494	4,968,715	2,108,752	39,768	138,989	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet B
Part II
Date/Time Prepared:
5/24/2019 2:49 pm

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.03	00401	ADMITTING						4.03
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	399,043					10.00
11.00	01100	CAFETERIA	207,104	241,470				11.00
13.00	01300	NURSING ADMINISTRATION	0	4,150	119,175			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,358	0	149,270		14.00
15.00	01500	PHARMACY	0	8,502	0	0	766,863	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,780	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	6,318	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	66,226	63,501	84,522	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	7,605	10,980	14,616	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	8,932	6,595	8,781	0	0	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	15,989	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	2,577	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	557	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,114	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	851	0	0	0	56.00
57.00	05700	CT SCAN	0	1,701	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,060	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,118	0	0	0	59.00
60.00	06000	LABORATORY	0	11,587	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	2,114	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	5,533	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	6,429	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,602	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	991	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	6,017	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	45,951	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	103,319	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	766,863	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0	6,285	5,494	0	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	4,423	5,762	0	0	76.01
76.02	03550	OP PSYCH	0	2,750	0	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	18,632	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	21,316	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	289,867	233,830	119,175	149,270	766,863	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	409	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	136	0	0	0	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	0	826	0	0	0	193.01
193.02	19302	MEDICAL OFFICE BUILDING	0	2,841	0	0	0	193.02
193.03	19303	HOME CARE PHARMACY	0	1,900	0	0	0	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	84,217	0	0	0	0	193.05
193.06	19306	VACANT SPACE	0	0	0	0	0	193.06
193.07	19307	POB 2	0	1,528	0	0	0	193.07
193.08	19308	NON REIMBURSABLE MEALS	24,959	0	0	0	0	193.08
193.09	19309	COFFEE BAR	0	0	0	0	0	193.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	57,220	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	399,043	298,690	119,175	149,270	766,863	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet B
Part II
Date/Time Prepared:
5/24/2019 2:49 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.03	00401	ADMITTING						4.03
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
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	126,977					16.00
17.00	01700	SOCIAL SERVICE	0	104,852				17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,496	85,125	2,657,828	0	2,657,828	30.00
31.00	03100	INTENSIVE CARE UNIT	2,432	9,072	330,061	0	330,061	31.00
40.00	04000	SUBPROVIDER - IPF	1,356	10,655	267,143	0	267,143	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,628	0	1,130,333	0	1,130,333	50.00
51.00	05100	RECOVERY ROOM	1,611	0	136,924	0	136,924	51.00
53.00	05300	ANESTHESIOLOGY	2,710	0	38,691	0	38,691	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,923	0	1,211,052	0	1,211,052	54.00
56.00	05600	RADIOISOTOPE	684	0	46,135	0	46,135	56.00
57.00	05700	CT SCAN	11,466	0	237,365	0	237,365	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,173	0	145,093	0	145,093	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,235	0	216,600	0	216,600	59.00
60.00	06000	LABORATORY	11,999	0	590,497	0	590,497	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,308	0	72,946	0	72,946	63.00
65.00	06500	RESPIRATORY THERAPY	1,494	0	167,522	0	167,522	65.00
66.00	06600	PHYSICAL THERAPY	1,993	0	216,816	0	216,816	66.00
67.00	06700	OCCUPATIONAL THERAPY	370	0	52,824	0	52,824	67.00
68.00	06800	SPEECH PATHOLOGY	290	0	25,692	0	25,692	68.00
69.00	06900	ELECTROCARDIOLOGY	6,496	0	286,277	0	286,277	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,193	0	214,128	0	214,128	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,329	0	479,600	0	479,600	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,296	0	784,867	0	784,867	73.00
74.00	07400	RENAL DIALYSIS	247	0	23,338	0	23,338	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	1,679	0	162,610	0	162,610	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	1,992	0	291,378	0	291,378	76.01
76.02	03550	OP PSYCH	462	0	123,346	0	123,346	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	486	0	8,790	0	8,790	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	18,292	0	644,551	0	644,551	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	4,337	0	644,960	0	644,960	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	126,977	104,852	11,207,367	0	11,207,367	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	52,406	0	52,406	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	33,087	0	33,087	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	0	0	73,388	0	73,388	193.01
193.02	19302	MEDICAL OFFICE BUILDING	0	0	41,214	0	41,214	193.02
193.03	19303	HOME CARE PHARMACY	0	0	81,412	0	81,412	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	84,217	0	84,217	193.05
193.06	19306	VACANT SPACE	0	0	780,104	0	780,104	193.06
193.07	19307	POB 2	0	0	31,133	0	31,133	193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	24,959	0	24,959	193.08
193.09	19309	COFFEE BAR	0	0	5,995	0	5,995	193.09
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	57,220	0	57,220	201.00
202.00		TOTAL (sum lines 118 through 201)	126,977	104,852	12,472,502	0	12,472,502	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018

Worksheet B-1

Date/Time Prepared:
5/24/2019 2:49 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS REVENUE)	Reconciliation	
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00				
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	451,642					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		6,459,673				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,460	2,364	43,809,536			4.00
4.03	00401	ADMITTING	5,429	7,936	1,120,632	520,128,036		4.03
5.00	00500	ADMINISTRATIVE & GENERAL	25,446	4,033,853	2,992,452	0	-29,581,475	5.00
7.00	00700	OPERATION OF PLANT	175,706	27,111	847,485	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,100	262	0	0	0	8.00
9.00	00900	HOUSEKEEPING	2,601	5,453	1,091,412	0	0	9.00
10.00	01000	DIETARY	10,795	18,259	0	0	0	10.00
11.00	01100	CAFETERIA	4,668	0	0	0	454,193	11.00
13.00	01300	NURSING ADMINISTRATION	495	37,767	957,605	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,456	38,430	241,187	0	0	14.00
15.00	01500	PHARMACY	2,770	3,878	1,860,530	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,311	1,385	158,243	0	0	16.00
17.00	01700	SOCIAL SERVICE	524	2,542	1,098,838	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	54,873	120,196	9,929,245	51,213,318	0	30.00
31.00	03100	INTENSIVE CARE UNIT	5,488	22,799	2,106,858	9,965,744	0	31.00
40.00	04000	SUBPROVIDER - IPF	7,348	296	1,201,317	5,556,608	0	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	20,705	288,493	2,710,858	39,460,526	0	50.00
51.00	05100	RECOVERY ROOM	3,381	21,204	534,942	6,601,592	0	51.00
53.00	05300	ANESTHESIOLOGY	244	13,934	63,286	11,108,034	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,919	735,344	2,245,695	40,666,549	0	54.00
56.00	05600	RADIOISOTOPE	1,001	1,077	199,139	2,804,145	0	56.00
57.00	05700	CT SCAN	569	161,134	279,564	46,992,887	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,807	1,716	482,132	13,003,418	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,761	120,704	541,716	9,158,917	0	59.00
60.00	06000	LABORATORY	14,381	45,635	1,233,138	49,177,888	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	364	5,796	309,829	5,358,766	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,542	17,905	909,098	6,121,180	0	65.00
66.00	06600	PHYSICAL THERAPY	5,425	14,630	1,170,740	8,169,919	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,461	2,769	289,137	1,515,370	0	67.00
68.00	06800	SPEECH PATHOLOGY	500	0	226,052	1,189,053	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,052	85,828	974,830	26,623,615	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	13,088,060	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	25,940,023	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	33,999,423	0	73.00
74.00	07400	RENAL DIALYSIS	280	0	0	1,011,882	0	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	1,777	39,014	919,060	6,879,866	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	3,422	125,491	809,936	8,165,066	0	76.01
76.02	03550	OP PSYCH	3,882	11,967	371,093	1,891,872	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	1,991,479	0	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	16,626	28,591	3,009,075	74,698,306	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	976	413,422	2,040,483	17,774,530	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	408,545	6,457,185	42,925,607	520,128,036	-29,127,282	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,036	567	30,513	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	1,596	228	8,965	0	0	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	1,041	904	171,985	0	0	193.01
193.02	19302	MEDICAL OFFICE BUILDING	0	0	265,156	0	0	193.02
193.03	19303	HOME CARE PHARMACY	481	789	293,337	0	0	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	0	0	0	193.05
193.06	19306	VACANT SPACE	38,761	0	0	0	0	193.06
193.07	19307	POB 2	0	0	113,973	0	0	193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	0	0	0	193.08
193.09	19309	COFFEE BAR	182	0	0	0	0	193.09
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)	4,672,629	6,511,392	1,194,137	1,590,155		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018

Worksheet B-1

Date/Time Prepared:
5/24/2019 2:49 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS REVENUE)	Reconciliation	
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	4.03	5A	
203.00		Unit cost multiplier (Wkst. B, Part I)	10.345869	1.008006	0.027257	0.003057		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			33,386	70,494		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000762	0.000136		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018

Worksheet B-1

Date/Time Prepared:
5/24/2019 2:49 pm

Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
4.03	00401	ADMITTING					4.03
5.00	00500	ADMINISTRATIVE & GENERAL	101,573,514				5.00
7.00	00700	OPERATION OF PLANT	5,268,023	242,601			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	379,474	1,100	718,735		8.00
9.00	00900	HOUSEKEEPING	1,689,604	2,601	0	238,900	9.00
10.00	01000	DIETARY	3,267,565	10,795	0	10,795	389,132
11.00	01100	CAFETERIA	0	4,668	0	4,668	201,961
13.00	01300	NURSING ADMINISTRATION	1,359,727	495	0	495	0
14.00	01400	CENTRAL SERVICES & SUPPLY	402,552	4,456	7,956	4,456	0
15.00	01500	PHARMACY	11,730,422	2,770	681	2,770	0
16.00	01600	MEDICAL RECORDS & LIBRARY	319,275	5,311	0	5,311	0
17.00	01700	SOCIAL SERVICE	1,679,949	524	0	524	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	15,016,660	54,873	255,548	54,873	64,581
31.00	03100	INTENSIVE CARE UNIT	3,000,539	5,488	49,572	5,488	7,416
40.00	04000	SUBPROVIDER - IPF	1,677,523	7,348	15,850	7,348	8,710
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,820,452	20,705	95,903	20,705	0
51.00	05100	RECOVERY ROOM	867,541	3,381	15,430	3,381	0
53.00	05300	ANESTHESIOLOGY	307,289	244	0	244	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,444,593	10,919	36,592	10,919	0
56.00	05600	RADIOISOTOPE	474,065	1,001	2,745	1,001	0
57.00	05700	CT SCAN	878,905	569	18,310	569	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	783,291	4,807	2,597	4,807	0
59.00	05900	CARDIAC CATHETERIZATION	1,065,935	1,761	14,925	1,761	0
60.00	06000	LABORATORY	4,325,270	14,381	0	14,381	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,136,116	364	0	364	0
65.00	06500	RESPIRATORY THERAPY	1,419,837	1,542	0	1,542	0
66.00	06600	PHYSICAL THERAPY	1,668,290	5,425	12,583	5,425	0
67.00	06700	OCCUPATIONAL THERAPY	387,820	1,461	0	1,461	0
68.00	06800	SPEECH PATHOLOGY	291,651	500	0	500	0
69.00	06900	ELECTROCARDIOLOGY	1,672,014	5,052	420	5,052	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,336,345	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	7,490,734	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	103,936	0	0	0	0
74.00	07400	RENAL DIALYSIS	356,919	280	0	280	0
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	1,381,820	1,777	0	1,777	0
76.01	03340	GASTRO INTESTINAL SERVICES	1,567,524	3,422	31,187	3,422	0
76.02	03550	OP PSYCH	573,240	3,882	63	3,882	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	161,879	0	2,058	0	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	4,698,840	16,626	124,464	16,626	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	3,636,383	976	31,851	976	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	96,642,002	199,504	718,735	195,803	282,668
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	635,278	1,036	0	1,036	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0
193.00	19300	NONPAID WORKERS	28,611	1,596	0	1,596	0
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	1,033,022	1,041	0	1,041	0
193.02	19302	MEDICAL OFFICE BUILDING	780,321	0	0	0	0
193.03	19303	HOME CARE PHARMACY	1,400,287	481	0	481	0
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0
193.05	19305	EUNICE SMITH NURSING HOME	0	0	0	0	82,125
193.06	19306	VACANT SPACE	401,016	38,761	0	38,761	0
193.07	19307	POB 2	603,429	0	0	0	0
193.08	19308	NON REIMBURSABLE MEALS	0	0	0	0	24,339
193.09	19309	COFFEE BAR	49,548	182	0	182	0
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers					0
202.00		Cost to be allocated (per Wkst. B, Part I)	29,581,475	6,802,240	520,832	2,254,600	4,623,740
203.00		Unit cost multiplier (Wkst. B, Part I)	0.291232	28.038796	0.724651	9.437422	11.882189
204.00		Cost to be allocated (per Wkst. B, Part II)	4,968,715	2,108,752	39,768	138,989	399,043

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018

Worksheet B-1

Date/Time Prepared:
5/24/2019 2:49 pm

Cost Center Description			ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			5.00	7.00	8.00	9.00	10.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	0.048917	8.692264	0.055331	0.581787	1.025470	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018

Worksheet B-1

Date/Time Prepared:
5/24/2019 2:49 pm

Cost Center Description			CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQUISITIONS)	PHARMACY (COSTED REQUISITIONS)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.03	00401	ADMITTING						4.03
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	58,476					11.00
13.00	01300	NURSING ADMINISTRATION	1,005	450,895				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	571	0	10,707,770			14.00
15.00	01500	PHARMACY	2,059	0	0	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	431	0	0	0	520,128,036	16.00
17.00	01700	SOCIAL SERVICE	1,530	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,378	319,786	0	0	51,213,318	30.00
31.00	03100	INTENSIVE CARE UNIT	2,659	55,299	0	0	9,965,744	31.00
40.00	04000	SUBPROVIDER - IPF	1,597	33,223	0	0	5,556,608	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,872	0	0	0	39,460,526	50.00
51.00	05100	RECOVERY ROOM	624	0	0	0	6,601,592	51.00
53.00	05300	ANESTHESIOLOGY	135	0	0	0	11,108,034	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,418	0	0	0	40,666,549	54.00
56.00	05600	RADIOISOTOPE	206	0	0	0	2,804,145	56.00
57.00	05700	CT SCAN	412	0	0	0	46,992,887	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	741	0	0	0	13,003,418	58.00
59.00	05900	CARDIAC CATHETERIZATION	755	0	0	0	9,158,917	59.00
60.00	06000	LABORATORY	2,806	0	0	0	49,177,888	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	512	0	0	0	5,358,766	63.00
65.00	06500	RESPIRATORY THERAPY	1,340	0	0	0	6,121,180	65.00
66.00	06600	PHYSICAL THERAPY	1,557	0	0	0	8,169,919	66.00
67.00	06700	OCCUPATIONAL THERAPY	388	0	0	0	1,515,370	67.00
68.00	06800	SPEECH PATHOLOGY	240	0	0	0	1,189,053	68.00
69.00	06900	ELECTROCARDIOLOGY	1,457	0	0	0	26,623,615	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	3,296,335	0	13,088,060	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	7,411,435	0	25,940,023	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	100	33,999,423	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	1,011,882	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	1,522	20,786	0	0	6,879,866	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	1,071	21,801	0	0	8,165,066	76.01
76.02	03550	OP PSYCH	666	0	0	0	1,891,872	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	1,991,479	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	4,512	0	0	0	74,698,306	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	5,162	0	0	0	17,774,530	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	56,626	450,895	10,707,770	100	520,128,036	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	99	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	33	0	0	0	0	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	200	0	0	0	0	193.01
193.02	19302	MEDICAL OFFICE BUILDING	688	0	0	0	0	193.02
193.03	19303	HOME CARE PHARMACY	460	0	0	0	0	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	0	0	0	193.05
193.06	19306	VACANT SPACE	0	0	0	0	0	193.06
193.07	19307	POB 2	370	0	0	0	0	193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	0	0	0	193.08
193.09	19309	COFFEE BAR	0	0	0	0	0	193.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,120,484	1,810,718	713,253	15,325,662	626,923	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	36.262467	4.015831	0.066611	153,256.620000	0.001205	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018

Worksheet B-1

Date/Time Prepared:
5/24/2019 2:49 pm

Cost Center Description		CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQUISITIONS)	PHARMACY (COSTED REQUISITIONS)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
		11.00	13.00	14.00	15.00	16.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	298,690	119,175	149,270	766,863	126,977	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	4.129386	0.264308	0.013940	7,668.630000	0.000244	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018

Worksheet B-1

Date/Time Prepared:
5/24/2019 2:49 pm

Cost Center Description		SOCIAL SERVICE	
		(PATIENT DAYS)	
		17.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
4.03	00401 ADMITTING		4.03
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
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	26,825	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	21,778	30.00
31.00	03100 INTENSIVE CARE UNIT	2,321	31.00
40.00	04000 SUBPROVIDER - IPF	2,726	40.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0	50.00
51.00	05100 RECOVERY ROOM	0	51.00
53.00	05300 ANESTHESIOLOGY	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	54.00
56.00	05600 RADIOISOTOPE	0	56.00
57.00	05700 CT SCAN	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	59.00
60.00	06000 LABORATORY	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	65.00
66.00	06600 PHYSICAL THERAPY	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	73.00
74.00	07400 RENAL DIALYSIS	0	74.00
76.00	03020 ONCOLOGY & PAIN MANAGEMENT	0	76.00
76.01	03340 GASTRO INTESTINAL SERVICES	0	76.01
76.02	03550 OP PSYCH	0	76.02
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	76.98
OUTPATIENT SERVICE COST CENTERS			
91.00	09100 EMERGENCY	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	0	95.00
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	26,825	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201 TWIN RIVERS MRI	0	192.01
193.00	19300 NONPAID WORKERS	0	193.00
193.01	19301 PHYSICIAN/PUBLIC RELATIONS	0	193.01
193.02	19302 MEDICAL OFFICE BUILDING	0	193.02
193.03	19303 HOME CARE PHARMACY	0	193.03
193.04	19304 MANAGEMENT SERVICES	0	193.04
193.05	19305 EUNICE SMITH NURSING HOME	0	193.05
193.06	19306 VACANT SPACE	0	193.06
193.07	19307 POB 2	0	193.07
193.08	19308 NON REIMBURSABLE MEALS	0	193.08
193.09	19309 COFFEE BAR	0	193.09
200.00	Cross Foot Adjustments		200.00
201.00	Negative Cost Centers		201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,244,323	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	83.665349	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	104,852	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018

Worksheet B-1

Date/Time Prepared:
5/24/2019 2:49 pm

Cost Center Description		SOCIAL SERVICE	
		(PATIENT DAYS)	
		17.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	3.908742	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)		206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet C
Part I
Date/Time Prepared:
5/24/2019 2:49 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	26,124,625		26,124,625	0	26,124,625	30.00
31.00	03100	INTENSIVE CARE UNIT	4,728,791		4,728,791	0	4,728,791	31.00
40.00	04000	SUBPROVIDER - IPF	2,982,523		2,982,523	0	2,982,523	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,131,417		11,131,417	0	11,131,417	50.00
51.00	05100	RECOVERY ROOM	1,288,668		1,288,668	0	1,288,668	51.00
53.00	05300	ANESTHESIOLOGY	424,205		424,205	0	424,205	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,347,668		6,347,668	0	6,347,668	54.00
56.00	05600	RADIOISOTOPE	662,480		662,480	0	662,480	56.00
57.00	05700	CT SCAN	1,241,028		1,241,028	0	1,241,028	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,235,979		1,235,979	0	1,235,979	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,491,593		1,491,593	0	1,491,593	59.00
60.00	06000	LABORATORY	6,284,884		6,284,884	0	6,284,884	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,505,653		1,505,653	0	1,505,653	63.00
65.00	06500	RESPIRATORY THERAPY	1,947,096	0	1,947,096	0	1,947,096	65.00
66.00	06600	PHYSICAL THERAPY	2,432,881	0	2,432,881	0	2,432,881	66.00
67.00	06700	OCCUPATIONAL THERAPY	571,415	0	571,415	0	571,415	67.00
68.00	06800	SPEECH PATHOLOGY	405,463	0	405,463	0	405,463	68.00
69.00	06900	ELECTROCARDIOLOGY	2,433,507		2,433,507	0	2,433,507	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,543,338		4,543,338	0	4,543,338	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	10,197,214		10,197,214	0	10,197,214	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,500,836		15,500,836	0	15,500,836	73.00
74.00	07400	RENAL DIALYSIS	472,577		472,577	0	472,577	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	1,997,799		1,997,799	0	1,997,799	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	2,311,106		2,311,106	0	2,311,106	76.01
76.02	03550	OP PSYCH	912,146		912,146	0	912,146	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	212,914		212,914	0	212,914	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	7,034,364		7,034,364	0	7,034,364	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,355,328		2,355,328	0	2,355,328	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	4,963,677		4,963,677	0	4,963,677	95.00
200.00		Subtotal (see instructions)	123,741,175	0	123,741,175	0	123,741,175	200.00
201.00		Less Observation Beds	2,355,328		2,355,328	0	2,355,328	201.00
202.00		Total (see instructions)	121,385,847	0	121,385,847	0	121,385,847	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet C
Part I
Date/Time Prepared:
5/24/2019 2:49 pm

			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			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	47,693,794		47,693,794			30.00
31.00	03100	INTENSIVE CARE UNIT	9,965,744		9,965,744			31.00
40.00	04000	SUBPROVIDER - IPF	5,556,608		5,556,608			40.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,371,003	29,089,523	39,460,526	0.282090	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,474,923	5,126,669	6,601,592	0.195206	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	3,908,252	7,199,782	11,108,034	0.038189	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,288,876	34,377,673	40,666,549	0.156091	0.000000	54.00
56.00	05600	RADIOISOTOPE	702,513	2,101,632	2,804,145	0.236250	0.000000	56.00
57.00	05700	CT SCAN	12,011,151	34,981,736	46,992,887	0.026409	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,421,406	11,582,012	13,003,418	0.095050	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,064,657	6,094,260	9,158,917	0.162857	0.000000	59.00
60.00	06000	LABORATORY	19,924,776	29,253,112	49,177,888	0.127799	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,635,599	2,723,167	5,358,766	0.280970	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	4,974,562	1,146,618	6,121,180	0.318092	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,461,664	6,708,255	8,169,919	0.297785	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	732,426	782,944	1,515,370	0.377080	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	180,059	1,008,994	1,189,053	0.340997	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	9,839,251	16,784,364	26,623,615	0.091404	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,497,347	7,590,713	13,088,060	0.347136	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	12,582,363	13,357,660	25,940,023	0.393107	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,867,013	27,132,410	33,999,423	0.455915	0.000000	73.00
74.00	07400	RENAL DIALYSIS	956,368	55,514	1,011,882	0.467028	0.000000	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	15,344	6,864,522	6,879,866	0.290383	0.000000	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	1,093,613	7,071,453	8,165,066	0.283048	0.000000	76.01
76.02	03550	OP PSYCH	4,233	1,987,246	1,991,479	0.458024	0.000000	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	22,512	1,869,360	1,891,872	0.112541	0.000000	76.98
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	13,673,013	61,025,293	74,698,306	0.094170	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	338,296	3,181,228	3,519,524	0.669218	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	17,340	17,757,190	17,774,530	0.279258	0.000000	95.00
200.00		Subtotal (see instructions)	183,274,706	336,853,330	520,128,036			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	183,274,706	336,853,330	520,128,036			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0002	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/24/2019 2:49 pm
			Title XVIII	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio		
			11.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.282090		50.00
51.00	05100	RECOVERY ROOM	0.195206		51.00
53.00	05300	ANESTHESIOLOGY	0.038189		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.156091		54.00
56.00	05600	RADIOISOTOPE	0.236250		56.00
57.00	05700	CT SCAN	0.026409		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.095050		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.162857		59.00
60.00	06000	LABORATORY	0.127799		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.280970		63.00
65.00	06500	RESPIRATORY THERAPY	0.318092		65.00
66.00	06600	PHYSICAL THERAPY	0.297785		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.377080		67.00
68.00	06800	SPEECH PATHOLOGY	0.340997		68.00
69.00	06900	ELECTROCARDIOLOGY	0.091404		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.347136		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.393107		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.455915		73.00
74.00	07400	RENAL DIALYSIS	0.467028		74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0.290383		76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0.283048		76.01
76.02	03550	OP PSYCH	0.458024		76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.112541		76.98
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.094170		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.669218		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.279258		95.00
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: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet C
Part I
Date/Time Prepared:
5/24/2019 2:49 pm

				Title XIX		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	26,124,625		26,124,625	0	26,124,625	30.00	
31.00	03100	INTENSIVE CARE UNIT	4,728,791		4,728,791	0	4,728,791	31.00	
40.00	04000	SUBPROVIDER - IPF	2,982,523		2,982,523	0	2,982,523	40.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	11,131,417		11,131,417	0	11,131,417	50.00	
51.00	05100	RECOVERY ROOM	1,288,668		1,288,668	0	1,288,668	51.00	
53.00	05300	ANESTHESIOLOGY	424,205		424,205	0	424,205	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,347,668		6,347,668	0	6,347,668	54.00	
56.00	05600	RADIOISOTOPE	662,480		662,480	0	662,480	56.00	
57.00	05700	CT SCAN	1,241,028		1,241,028	0	1,241,028	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,235,979		1,235,979	0	1,235,979	58.00	
59.00	05900	CARDIAC CATHETERIZATION	1,491,593		1,491,593	0	1,491,593	59.00	
60.00	06000	LABORATORY	6,284,884		6,284,884	0	6,284,884	60.00	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,505,653		1,505,653	0	1,505,653	63.00	
65.00	06500	RESPIRATORY THERAPY	1,947,096	0	1,947,096	0	1,947,096	65.00	
66.00	06600	PHYSICAL THERAPY	2,432,881	0	2,432,881	0	2,432,881	66.00	
67.00	06700	OCCUPATIONAL THERAPY	571,415	0	571,415	0	571,415	67.00	
68.00	06800	SPEECH PATHOLOGY	405,463	0	405,463	0	405,463	68.00	
69.00	06900	ELECTROCARDIOLOGY	2,433,507		2,433,507	0	2,433,507	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,543,338		4,543,338	0	4,543,338	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	10,197,214		10,197,214	0	10,197,214	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	15,500,836		15,500,836	0	15,500,836	73.00	
74.00	07400	RENAL DIALYSIS	472,577		472,577	0	472,577	74.00	
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	1,997,799		1,997,799	0	1,997,799	76.00	
76.01	03340	GASTRO INTESTINAL SERVICES	2,311,106		2,311,106	0	2,311,106	76.01	
76.02	03550	OP PSYCH	912,146		912,146	0	912,146	76.02	
76.98	07698	HYPERBARIC OXYGEN THERAPY	212,914		212,914	0	212,914	76.98	
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	7,034,364		7,034,364	0	7,034,364	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,355,328		2,355,328	0	2,355,328	92.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	4,963,677		4,963,677	0	4,963,677	95.00	
200.00		Subtotal (see instructions)	123,741,175	0	123,741,175	0	123,741,175	200.00	
201.00		Less Observation Beds	2,355,328		2,355,328		2,355,328	201.00	
202.00		Total (see instructions)	121,385,847	0	121,385,847	0	121,385,847	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet C
Part I
Date/Time Prepared:
5/24/2019 2:49 pm

			Title XIX		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
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	47,693,794		47,693,794		30.00	
31.00	03100	INTENSIVE CARE UNIT	9,965,744		9,965,744		31.00	
40.00	04000	SUBPROVIDER - IPF	5,556,608		5,556,608		40.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,371,003	29,089,523	39,460,526	0.282090	50.00	
51.00	05100	RECOVERY ROOM	1,474,923	5,126,669	6,601,592	0.195206	51.00	
53.00	05300	ANESTHESIOLOGY	3,908,252	7,199,782	11,108,034	0.038189	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,288,876	34,377,673	40,666,549	0.156091	54.00	
56.00	05600	RADIOISOTOPE	702,513	2,101,632	2,804,145	0.236250	56.00	
57.00	05700	CT SCAN	12,011,151	34,981,736	46,992,887	0.026409	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,421,406	11,582,012	13,003,418	0.095050	58.00	
59.00	05900	CARDIAC CATHETERIZATION	3,064,657	6,094,260	9,158,917	0.162857	59.00	
60.00	06000	LABORATORY	19,924,776	29,253,112	49,177,888	0.127799	60.00	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,635,599	2,723,167	5,358,766	0.280970	63.00	
65.00	06500	RESPIRATORY THERAPY	4,974,562	1,146,618	6,121,180	0.318092	65.00	
66.00	06600	PHYSICAL THERAPY	1,461,664	6,708,255	8,169,919	0.297785	66.00	
67.00	06700	OCCUPATIONAL THERAPY	732,426	782,944	1,515,370	0.377080	67.00	
68.00	06800	SPEECH PATHOLOGY	180,059	1,008,994	1,189,053	0.340997	68.00	
69.00	06900	ELECTROCARDIOLOGY	9,839,251	16,784,364	26,623,615	0.091404	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,497,347	7,590,713	13,088,060	0.347136	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	12,582,363	13,357,660	25,940,023	0.393107	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	6,867,013	27,132,410	33,999,423	0.455915	73.00	
74.00	07400	RENAL DIALYSIS	956,368	55,514	1,011,882	0.467028	74.00	
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	15,344	6,864,522	6,879,866	0.290383	76.00	
76.01	03340	GASTRO INTESTINAL SERVICES	1,093,613	7,071,453	8,165,066	0.283048	76.01	
76.02	03550	OP PSYCH	4,233	1,987,246	1,991,479	0.458024	76.02	
76.98	07698	HYPERBARIC OXYGEN THERAPY	22,512	1,869,360	1,891,872	0.112541	76.98	
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	13,673,013	61,025,293	74,698,306	0.094170	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	338,296	3,181,228	3,519,524	0.669218	92.00	
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	17,340	17,757,190	17,774,530	0.279258	95.00	
200.00		Subtotal (see instructions)	183,274,706	336,853,330	520,128,036		200.00	
201.00		Less Observation Beds					201.00	
202.00		Total (see instructions)	183,274,706	336,853,330	520,128,036		202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0002	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/24/2019 2:49 pm
			Title XIX	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio		
			11.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.282090		50.00
51.00	05100	RECOVERY ROOM	0.195206		51.00
53.00	05300	ANESTHESIOLOGY	0.038189		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.156091		54.00
56.00	05600	RADIOISOTOPE	0.236250		56.00
57.00	05700	CT SCAN	0.026409		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.095050		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.162857		59.00
60.00	06000	LABORATORY	0.127799		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.280970		63.00
65.00	06500	RESPIRATORY THERAPY	0.318092		65.00
66.00	06600	PHYSICAL THERAPY	0.297785		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.377080		67.00
68.00	06800	SPEECH PATHOLOGY	0.340997		68.00
69.00	06900	ELECTROCARDIOLOGY	0.091404		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.347136		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.393107		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.455915		73.00
74.00	07400	RENAL DIALYSIS	0.467028		74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0.290383		76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0.283048		76.01
76.02	03550	OP PSYCH	0.458024		76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.112541		76.98
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.094170		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.669218		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.279258		95.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet C
Part II
Date/Time Prepared:
5/24/2019 2:49 pm

Cost Center Description			Title XIX		Hospital	PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	11,131,417	1,130,333	10,001,084	0	0
51.00	05100	RECOVERY ROOM	1,288,668	136,924	1,151,744	0	0
53.00	05300	ANESTHESIOLOGY	424,205	38,691	385,514	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,347,668	1,211,052	5,136,616	0	0
56.00	05600	RADIOISOTOPE	662,480	46,135	616,345	0	0
57.00	05700	CT SCAN	1,241,028	237,365	1,003,663	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,235,979	145,093	1,090,886	0	0
59.00	05900	CARDIAC CATHETERIZATION	1,491,593	216,600	1,274,993	0	0
60.00	06000	LABORATORY	6,284,884	590,497	5,694,387	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,505,653	72,946	1,432,707	0	0
65.00	06500	RESPIRATORY THERAPY	1,947,096	167,522	1,779,574	0	0
66.00	06600	PHYSICAL THERAPY	2,432,881	216,816	2,216,065	0	0
67.00	06700	OCCUPATIONAL THERAPY	571,415	52,824	518,591	0	0
68.00	06800	SPEECH PATHOLOGY	405,463	25,692	379,771	0	0
69.00	06900	ELECTROCARDIOLOGY	2,433,507	286,277	2,147,230	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,543,338	214,128	4,329,210	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	10,197,214	479,600	9,717,614	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	15,500,836	784,867	14,715,969	0	0
74.00	07400	RENAL DIALYSIS	472,577	23,338	449,239	0	0
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	1,997,799	162,610	1,835,189	0	0
76.01	03340	GASTRO INTESTINAL SERVICES	2,311,106	291,378	2,019,728	0	0
76.02	03550	OP PSYCH	912,146	123,346	788,800	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	212,914	8,790	204,124	0	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	7,034,364	644,551	6,389,813	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,355,328	239,624	2,115,704	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	4,963,677	644,960	4,318,717	0	0
200.00		Subtotal (sum of lines 50 thru 199)	89,905,236	8,191,959	81,713,277	0	0
201.00		Less Observation Beds	2,355,328	239,624	2,115,704	0	0
202.00		Total (line 200 minus line 201)	87,549,908	7,952,335	79,597,573	0	0

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet C
Part II
Date/Time Prepared:
5/24/2019 2:49 pm

				Title XIX		Hospital	PPS	
Cost Center Description			Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)			
			6.00	7.00	8.00			
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	11,131,417	39,460,526	0.282090			50.00
51.00	05100	RECOVERY ROOM	1,288,668	6,601,592	0.195206			51.00
53.00	05300	ANESTHESIOLOGY	424,205	11,108,034	0.038189			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,347,668	40,666,549	0.156091			54.00
56.00	05600	RADIOISOTOPE	662,480	2,804,145	0.236250			56.00
57.00	05700	CT SCAN	1,241,028	46,992,887	0.026409			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,235,979	13,003,418	0.095050			58.00
59.00	05900	CARDIAC CATHETERIZATION	1,491,593	9,158,917	0.162857			59.00
60.00	06000	LABORATORY	6,284,884	49,177,888	0.127799			60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,505,653	5,358,766	0.280970			63.00
65.00	06500	RESPIRATORY THERAPY	1,947,096	6,121,180	0.318092			65.00
66.00	06600	PHYSICAL THERAPY	2,432,881	8,169,919	0.297785			66.00
67.00	06700	OCCUPATIONAL THERAPY	571,415	1,515,370	0.377080			67.00
68.00	06800	SPEECH PATHOLOGY	405,463	1,189,053	0.340997			68.00
69.00	06900	ELECTROCARDIOLOGY	2,433,507	26,623,615	0.091404			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,543,338	13,088,060	0.347136			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	10,197,214	25,940,023	0.393107			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,500,836	33,999,423	0.455915			73.00
74.00	07400	RENAL DIALYSIS	472,577	1,011,882	0.467028			74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	1,997,799	6,879,866	0.290383			76.00
76.01	03340	GASTRO INTESTINAL SERVICES	2,311,106	8,165,066	0.283048			76.01
76.02	03550	OP PSYCH	912,146	1,991,479	0.458024			76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	212,914	1,891,872	0.112541			76.98
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	7,034,364	74,698,306	0.094170			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,355,328	3,519,524	0.669218			92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	4,963,677	17,774,530	0.279258			95.00
200.00		Subtotal (sum of lines 50 thru 199)	89,905,236	456,911,890				200.00
201.00		Less Observation Beds	2,355,328	0				201.00
202.00		Total (line 200 minus line 201)	87,549,908	456,911,890				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS				Provider CCN: 14-0002		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part I Date/Time Prepared: 5/24/2019 2:49 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)			
		1.00	2.00	3.00	4.00	5.00			
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	2,657,828	0	2,657,828	23,936	111.04	30.00		
31.00	INTENSIVE CARE UNIT	330,061		330,061	2,321	142.21	31.00		
40.00	SUBPROVIDER - IPF	267,143	0	267,143	2,726	98.00	40.00		
200.00	Total (lines 30 through 199)	3,255,032		3,255,032	28,983		200.00		
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)						
		6.00	7.00						
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	9,507	1,055,657					30.00	
31.00	INTENSIVE CARE UNIT	1,066	151,596					31.00	
40.00	SUBPROVIDER - IPF	1,939	190,022					40.00	
200.00	Total (lines 30 through 199)	12,512	1,397,275					200.00	

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0002	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Prepared: 5/24/2019 2:49 pm		
				Title XVIII		Hospital		PPS
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,130,333	39,460,526	0.028645	5,092,010	145,861	50.00
51.00	05100	RECOVERY ROOM	136,924	6,601,592	0.020741	676,709	14,036	51.00
53.00	05300	ANESTHESIOLOGY	38,691	11,108,034	0.003483	1,788,662	6,230	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,211,052	40,666,549	0.029780	2,029,310	60,433	54.00
56.00	05600	RADIOISOTOPE	46,135	2,804,145	0.016452	345,873	5,690	56.00
57.00	05700	CT SCAN	237,365	46,992,887	0.005051	5,531,199	27,938	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	145,093	13,003,418	0.011158	631,764	7,049	58.00
59.00	05900	CARDIAC CATHETERIZATION	216,600	9,158,917	0.023649	676,296	15,994	59.00
60.00	06000	LABORATORY	590,497	49,177,888	0.012007	9,852,601	118,300	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	72,946	5,358,766	0.013612	555,170	7,557	63.00
65.00	06500	RESPIRATORY THERAPY	167,522	6,121,180	0.027368	2,643,647	72,351	65.00
66.00	06600	PHYSICAL THERAPY	216,816	8,169,919	0.026538	785,949	20,858	66.00
67.00	06700	OCCUPATIONAL THERAPY	52,824	1,515,370	0.034859	388,992	13,560	67.00
68.00	06800	SPEECH PATHOLOGY	25,692	1,189,053	0.021607	93,511	2,020	68.00
69.00	06900	ELECTROCARDIOLOGY	286,277	26,623,615	0.010753	6,018,077	64,712	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	214,128	13,088,060	0.016361	2,479,449	40,566	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	479,600	25,940,023	0.018489	5,469,025	101,117	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	784,867	33,999,423	0.023085	5,387,127	124,362	73.00
74.00	07400	RENAL DIALYSIS	23,338	1,011,882	0.023064	708,920	16,351	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	162,610	6,879,866	0.023636	1,071	25	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	291,378	8,165,066	0.035686	447,922	15,985	76.01
76.02	03550	OP PSYCH	123,346	1,991,479	0.061937	1,863	115	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	8,790	1,891,872	0.004646	0	0	76.98
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	644,551	74,698,306	0.008629	5,415,295	46,729	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	239,624	3,519,524	0.068084	222,446	15,145	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	7,546,999	439,137,360		57,242,888	942,984	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0002		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part III Date/Time Prepared: 5/24/2019 2:49 pm	
					Title XVIII		Hospital		PPS	
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
					1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF		0	0	0	0	0	0	40.00
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
					4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	23,936	0.00		9,507	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	2,321	0.00		1,066	31.00
40.00	04000	SUBPROVIDER - IPF		0	0	2,726	0.00		1,939	40.00
200.00		Total (lines 30 through 199)		0	0	28,983			12,512	200.00
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost				
					9.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0					30.00
31.00	03100	INTENSIVE CARE UNIT		0	0					31.00
40.00	04000	SUBPROVIDER - IPF		0	0					40.00
200.00		Total (lines 30 through 199)		0	0					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0002		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part IV Date/Time Prepared: 5/24/2019 2:49 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0	0	0	0	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.01
76.02	03550	OP PSYCH	0	0	0	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet D
Part IV
Date/Time Prepared:
5/24/2019 2:49 pm

				Title XVIII		Hospital	PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	39,460,526	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	6,601,592	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	11,108,034	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	40,666,549	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	2,804,145	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	46,992,887	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	13,003,418	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	9,158,917	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	49,177,888	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	5,358,766	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,121,180	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,169,919	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,515,370	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,189,053	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	26,623,615	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	13,088,060	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	25,940,023	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	33,999,423	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,011,882	0.000000	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0	0	0	6,879,866	0.000000	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	0	0	8,165,066	0.000000	76.01
76.02	03550	OP PSYCH	0	0	0	1,991,479	0.000000	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	1,891,872	0.000000	76.98
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	74,698,306	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,519,524	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	439,137,360		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet D
Part IV
Date/Time Prepared:
5/24/2019 2:49 pm

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								
50.00	05000	OPERATING ROOM	0.000000	5,092,010	0	12,066,005	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	676,709	0	1,394,299	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	1,788,662	0	1,901,893	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,029,310	0	10,066,859	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	345,873	0	664,155	0	56.00
57.00	05700	CT SCAN	0.000000	5,531,199	0	10,518,333	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	631,764	0	3,493,018	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	676,296	0	1,185,991	0	59.00
60.00	06000	LABORATORY	0.000000	9,852,601	0	5,112,402	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	555,170	0	120,899	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	2,643,647	0	349,289	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	785,949	0	108,715	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	388,992	0	44,251	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	93,511	0	2,659	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	6,018,077	0	6,935,889	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	2,479,449	0	1,793,308	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	5,469,025	0	5,764,949	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	5,387,127	0	16,782,628	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	708,920	0	0	0	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0.000000	1,071	0	754,905	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0.000000	447,922	0	2,085,203	0	76.01
76.02	03550	OP PSYCH	0.000000	1,863	0	1,552,037	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	898,872	0	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.000000	5,415,295	0	10,095,287	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	222,446	0	922,327	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		57,242,888	0	94,614,173	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0002		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part IV Date/Time Prepared: 5/24/2019 2:49 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description				PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost				
				21.00	24.00				
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0					
51.00	05100	RECOVERY ROOM	0	0					
53.00	05300	ANESTHESIOLOGY	0	0					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					
56.00	05600	RADIOISOTOPE	0	0					
57.00	05700	CT SCAN	0	0					
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0					
59.00	05900	CARDIAC CATHETERIZATION	0	0					
60.00	06000	LABORATORY	0	0					
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0					
65.00	06500	RESPIRATORY THERAPY	0	0					
66.00	06600	PHYSICAL THERAPY	0	0					
67.00	06700	OCCUPATIONAL THERAPY	0	0					
68.00	06800	SPEECH PATHOLOGY	0	0					
69.00	06900	ELECTROCARDIOLOGY	0	0					
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0					
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0					
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0					
74.00	07400	RENAL DIALYSIS	0	0					
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0	0					
76.01	03340	GASTRO INTESTINAL SERVICES	0	0					
76.02	03550	OP PSYCH	0	0					
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0					
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	0	0					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0					
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							
200.00		Total (lines 50 through 199)	0	0					

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0002		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part V Date/Time Prepared: 5/24/2019 2:49 pm	
				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									
50.00	05000	OPERATING ROOM		0.282090	12,066,005	0	0	3,403,699	50.00
51.00	05100	RECOVERY ROOM		0.195206	1,394,299	0	0	272,176	51.00
53.00	05300	ANESTHESIOLOGY		0.038189	1,901,893	0	0	72,631	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.156091	10,066,859	0	0	1,571,346	54.00
56.00	05600	RADIOISOTOPE		0.236250	664,155	0	0	156,907	56.00
57.00	05700	CT SCAN		0.026409	10,518,333	0	0	277,779	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.095050	3,493,018	0	0	332,011	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.162857	1,185,991	0	0	193,147	59.00
60.00	06000	LABORATORY		0.127799	5,112,402	0	586	653,360	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0.280970	120,899	0	0	33,969	63.00
65.00	06500	RESPIRATORY THERAPY		0.318092	349,289	0	0	111,106	65.00
66.00	06600	PHYSICAL THERAPY		0.297785	108,715	0	0	32,374	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.377080	44,251	0	0	16,686	67.00
68.00	06800	SPEECH PATHOLOGY		0.340997	2,659	0	0	907	68.00
69.00	06900	ELECTROCARDIOLOGY		0.091404	6,935,889	0	0	633,968	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.347136	1,793,308	0	0	622,522	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT		0.393107	5,764,949	0	0	2,266,242	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.455915	16,782,628	22,702	0	7,651,452	73.00
74.00	07400	RENAL DIALYSIS		0.467028	0	0	0	0	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT		0.290383	754,905	0	0	219,212	76.00
76.01	03340	GASTRO INTESTINAL SERVICES		0.283048	2,085,203	0	0	590,213	76.01
76.02	03550	OP PSYCH		0.458024	1,552,037	0	0	710,870	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY		0.112541	898,872	0	0	101,160	76.98
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY		0.094170	10,095,287	0	0	950,673	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.669218	922,327	0	0	617,238	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES		0.279258		0			95.00
200.00		Subtotal (see instructions)			94,614,173	22,702	586	21,491,648	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0		201.00
202.00		Net Charges (line 200 - line 201)			94,614,173	22,702	586	21,491,648	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0002		Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/24/2019 2:49 pm
			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						
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	75		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,350	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0	0		76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	0		76.01
76.02	03550	OP PSYCH	0	0		76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	10,350	75		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	10,350	75		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0002	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Prepared: 5/24/2019 2:49 pm	
				Component CCN: 14-S002			
				Title XVIII		Subprovider - IPF	PPS
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,130,333	39,460,526	0.028645	0	0
51.00	05100	RECOVERY ROOM	136,924	6,601,592	0.020741	0	0
53.00	05300	ANESTHESIOLOGY	38,691	11,108,034	0.003483	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,211,052	40,666,549	0.029780	53,943	1,606
56.00	05600	RADIOISOTOPE	46,135	2,804,145	0.016452	0	0
57.00	05700	CT SCAN	237,365	46,992,887	0.005051	200,369	1,012
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	145,093	13,003,418	0.011158	2,303	26
59.00	05900	CARDIAC CATHETERIZATION	216,600	9,158,917	0.023649	48,801	1,154
60.00	06000	LABORATORY	590,497	49,177,888	0.012007	317,366	3,811
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	72,946	5,358,766	0.013612	0	0
65.00	06500	RESPIRATORY THERAPY	167,522	6,121,180	0.027368	11,055	303
66.00	06600	PHYSICAL THERAPY	216,816	8,169,919	0.026538	24,570	652
67.00	06700	OCCUPATIONAL THERAPY	52,824	1,515,370	0.034859	7,035	245
68.00	06800	SPEECH PATHOLOGY	25,692	1,189,053	0.021607	9,481	205
69.00	06900	ELECTROCARDIOLOGY	286,277	26,623,615	0.010753	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	214,128	13,088,060	0.016361	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	479,600	25,940,023	0.018489	62	1
73.00	07300	DRUGS CHARGED TO PATIENTS	784,867	33,999,423	0.023085	90,894	2,098
74.00	07400	RENAL DIALYSIS	23,338	1,011,882	0.023064	0	0
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	162,610	6,879,866	0.023636	771	18
76.01	03340	GASTRO INTESTINAL SERVICES	291,378	8,165,066	0.035686	0	0
76.02	03550	OP PSYCH	123,346	1,991,479	0.061937	752	47
76.98	07698	HYPERBARIC OXYGEN THERAPY	8,790	1,891,872	0.004646	0	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	644,551	74,698,306	0.008629	272,686	2,353
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,519,524	0.000000	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					
200.00		Total (lines 50 through 199)	7,307,375	439,137,360		1,040,088	13,531

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0002 Component CCN: 14-S002		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part IV Date/Time Prepared: 5/24/2019 2:49 pm	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0	0	0	0	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.01
76.02	03550	OP PSYCH	0	0	0	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0002 Component CCN: 14-S002		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part IV Date/Time Prepared: 5/24/2019 2:49 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	39,460,526	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	6,601,592	0.000000	51.00
53.00	05300	ANESTHESIOLOGY		0	0	0	11,108,034	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	40,666,549	0.000000	54.00
56.00	05600	RADIOISOTOPE		0	0	0	2,804,145	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	46,992,887	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	13,003,418	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	9,158,917	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	49,177,888	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0	0	0	5,358,766	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	6,121,180	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	8,169,919	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	1,515,370	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	1,189,053	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	26,623,615	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	13,088,060	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT		0	0	0	25,940,023	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	33,999,423	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	1,011,882	0.000000	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT		0	0	0	6,879,866	0.000000	76.00
76.01	03340	GASTRO INTESTINAL SERVICES		0	0	0	8,165,066	0.000000	76.01
76.02	03550	OP PSYCH		0	0	0	1,991,479	0.000000	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	1,891,872	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY		0	0	0	74,698,306	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	3,519,524	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)		0	0	0	439,137,360		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0002 Component CCN: 14-S002		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part IV Date/Time Prepared: 5/24/2019 2:49 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	53,943	0	0	0	54.00
56.00	05600	RADIOISOTOPE		0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN		0.000000	200,369	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	2,303	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	48,801	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	317,366	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY		0.000000	11,055	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	24,570	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	7,035	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	9,481	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT		0.000000	62	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	90,894	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	0	0	0	0	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT		0.000000	771	0	0	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES		0.000000	0	0	0	0	76.01
76.02	03550	OP PSYCH		0.000000	752	0	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY		0.000000	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY		0.000000	272,686	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)			1,040,088	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0002 Component CCN: 14-S002		Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/24/2019 2:49 pm
				Title XVIII		Subprovider - IPF	PPS
Cost Center Description			PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost			
			21.00	24.00			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0			50.00
51.00	05100	RECOVERY ROOM	0	0			51.00
53.00	05300	ANESTHESIOLOGY	0	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0			54.00
56.00	05600	RADIOISOTOPE	0	0			56.00
57.00	05700	CT SCAN	0	0			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0			59.00
60.00	06000	LABORATORY	0	0			60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0			63.00
65.00	06500	RESPIRATORY THERAPY	0	0			65.00
66.00	06600	PHYSICAL THERAPY	0	0			66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0			67.00
68.00	06800	SPEECH PATHOLOGY	0	0			68.00
69.00	06900	ELECTROCARDIOLOGY	0	0			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0			73.00
74.00	07400	RENAL DIALYSIS	0	0			74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0	0			76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	0			76.01
76.02	03550	OP PSYCH	0	0			76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0			76.98
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)	0	0			200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS					Provider CCN: 14-0002		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part I Date/Time Prepared: 5/24/2019 2:49 pm		
					Title XIX		Hospital		PPS		
Cost Center Description					Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
					1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	ADULTS & PEDIATRICS	2,657,828	0	2,657,828	23,936	111.04	30.00				
31.00	INTENSIVE CARE UNIT	330,061		330,061	2,321	142.21	31.00				
40.00	SUBPROVIDER - IPF	267,143	0	267,143	2,726	98.00	40.00				
200.00	Total (lines 30 through 199)	3,255,032		3,255,032	28,983		200.00				
Cost Center Description					Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
					6.00	7.00					
	INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	ADULTS & PEDIATRICS	1,733	192,432					30.00			
31.00	INTENSIVE CARE UNIT	77	10,950					31.00			
40.00	SUBPROVIDER - IPF	0	0					40.00			
200.00	Total (lines 30 through 199)	1,810	203,382					200.00			

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0002	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Prepared: 5/24/2019 2:49 pm	
				Title XIX		Hospital	PPS
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,130,333	39,460,526	0.028645	483,483	13,849
51.00	05100	RECOVERY ROOM	136,924	6,601,592	0.020741	39,865	827
53.00	05300	ANESTHESIOLOGY	38,691	11,108,034	0.003483	101,976	355
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,211,052	40,666,549	0.029780	129,303	3,851
56.00	05600	RADIOISOTOPE	46,135	2,804,145	0.016452	12,593	207
57.00	05700	CT SCAN	237,365	46,992,887	0.005051	286,413	1,447
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	145,093	13,003,418	0.011158	33,274	371
59.00	05900	CARDIAC CATHETERIZATION	216,600	9,158,917	0.023649	94,164	2,227
60.00	06000	LABORATORY	590,497	49,177,888	0.012007	715,413	8,590
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	72,946	5,358,766	0.013612	134,191	1,827
65.00	06500	RESPIRATORY THERAPY	167,522	6,121,180	0.027368	129,932	3,556
66.00	06600	PHYSICAL THERAPY	216,816	8,169,919	0.026538	15,041	399
67.00	06700	OCCUPATIONAL THERAPY	52,824	1,515,370	0.034859	6,912	241
68.00	06800	SPEECH PATHOLOGY	25,692	1,189,053	0.021607	1,591	34
69.00	06900	ELECTROCARDIOLOGY	286,277	26,623,615	0.010753	265,061	2,850
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	214,128	13,088,060	0.016361	16,414	269
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	479,600	25,940,023	0.018489	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	784,867	33,999,423	0.023085	209,640	4,840
74.00	07400	RENAL DIALYSIS	23,338	1,011,882	0.023064	15,106	348
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	162,610	6,879,866	0.023636	0	0
76.01	03340	GASTRO INTESTINAL SERVICES	291,378	8,165,066	0.035686	10,795	385
76.02	03550	OP PSYCH	123,346	1,991,479	0.061937	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	8,790	1,891,872	0.004646	0	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	644,551	74,698,306	0.008629	445,348	3,843
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	239,624	3,519,524	0.068084	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					
200.00		Total (lines 50 through 199)	7,546,999	439,137,360		3,146,515	50,316

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0002		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part III Date/Time Prepared: 5/24/2019 2:49 pm	
					Title XIX		Hospital		PPS	
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
					1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF		0	0	0	0	0	0	40.00
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
					4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	23,936	0.00	1,733		30.00
31.00	03100	INTENSIVE CARE UNIT			0	2,321	0.00	77		31.00
40.00	04000	SUBPROVIDER - IPF		0	0	2,726	0.00	0		40.00
200.00		Total (lines 30 through 199)			0	28,983		1,810		200.00
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost				
					9.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0					30.00
31.00	03100	INTENSIVE CARE UNIT		0	0					31.00
40.00	04000	SUBPROVIDER - IPF		0	0					40.00
200.00		Total (lines 30 through 199)		0	0					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018

Worksheet D
Part IV
Date/Time Prepared:
5/24/2019 2:49 pm

Cost Center Description		Title XIX			Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
		1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0	0	0	0	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.01
76.02	03550	OP PSYCH	0	0	0	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0002		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part IV Date/Time Prepared: 5/24/2019 2:49 pm	
			Title XIX		Hospital		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	39,460,526	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	6,601,592	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	11,108,034	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	40,666,549	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	2,804,145	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	46,992,887	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	13,003,418	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	9,158,917	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	49,177,888	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	5,358,766	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,121,180	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,169,919	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,515,370	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,189,053	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	26,623,615	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	13,088,060	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	25,940,023	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	33,999,423	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,011,882	0.000000	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0	0	0	6,879,866	0.000000	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	0	0	8,165,066	0.000000	76.01
76.02	03550	OP PSYCH	0	0	0	1,991,479	0.000000	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	1,891,872	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	74,698,306	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,519,524	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	439,137,360		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0002		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part IV Date/Time Prepared: 5/24/2019 2:49 pm	
				Title XIX		Hospital		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000		483,483	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000		39,865	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000		101,976	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		129,303	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000		12,593	0	0	0	56.00
57.00	05700	CT SCAN	0.000000		286,413	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		33,274	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		94,164	0	0	0	59.00
60.00	06000	LABORATORY	0.000000		715,413	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		134,191	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000		129,932	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000		15,041	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		6,912	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		1,591	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		265,061	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		16,414	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		209,640	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000		15,106	0	0	0	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0.000000		0	0	0	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0.000000		10,795	0	0	0	76.01
76.02	03550	OP PSYCH	0.000000		0	0	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	0.000000		445,348	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)			3,146,515	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0002		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part IV Date/Time Prepared: 5/24/2019 2:49 pm	
				Title XIX		Hospital		PPS	
Cost Center Description				PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost				
				21.00	24.00				
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0					
51.00	05100	RECOVERY ROOM	0	0					
53.00	05300	ANESTHESIOLOGY	0	0					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					
56.00	05600	RADIOISOTOPE	0	0					
57.00	05700	CT SCAN	0	0					
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0					
59.00	05900	CARDIAC CATHETERIZATION	0	0					
60.00	06000	LABORATORY	0	0					
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0					
65.00	06500	RESPIRATORY THERAPY	0	0					
66.00	06600	PHYSICAL THERAPY	0	0					
67.00	06700	OCCUPATIONAL THERAPY	0	0					
68.00	06800	SPEECH PATHOLOGY	0	0					
69.00	06900	ELECTROCARDIOLOGY	0	0					
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0					
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0					
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0					
74.00	07400	RENAL DIALYSIS	0	0					
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0	0					
76.01	03340	GASTRO INTESTINAL SERVICES	0	0					
76.02	03550	OP PSYCH	0	0					
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0					
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	0	0					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0					
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							
200.00		Total (lines 50 through 199)	0	0					

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet D
Part V
Date/Time Prepared:
5/24/2019 2:49 pm

			Title XIX		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							
50.00	05000	OPERATING ROOM	0.282090	0	942,756	0	0	50.00
51.00	05100	RECOVERY ROOM	0.195206	0	165,385	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.038189	0	221,555	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.156091	0	1,004,689	0	0	54.00
56.00	05600	RADIOISOTOPE	0.236250	0	38,258	0	0	56.00
57.00	05700	CT SCAN	0.026409	0	1,160,769	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.095050	0	247,321	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.162857	0	76,660	0	0	59.00
60.00	06000	LABORATORY	0.127799	0	1,148,117	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.280970	0	220,395	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.318092	0	26,915	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.297785	0	169,006	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.377080	0	25,127	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.340997	0	52,629	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.091404	0	466,118	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.347136	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.393107	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.455915	0	1,590,522	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.467028	0	0	0	0	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0.290383	0	151,794	0	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0.283048	0	66,299	0	0	76.01
76.02	03550	OP PSYCH	0.458024	0	0	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.112541	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.094170	0	4,326,690	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.669218	0	184,619	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.279258	0	903,140			95.00
200.00		Subtotal (see instructions)		0	13,188,764	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0		201.00
		Only Charges						
202.00		Net Charges (line 200 - line 201)		0	13,188,764	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet D
Part V
Date/Time Prepared:
5/24/2019 2:49 pm

			Title XIX		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					
50.00	05000	OPERATING ROOM	265,942	0		50.00
51.00	05100	RECOVERY ROOM	32,284	0		51.00
53.00	05300	ANESTHESIOLOGY	8,461	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	156,823	0		54.00
56.00	05600	RADIOISOTOPE	9,038	0		56.00
57.00	05700	CT SCAN	30,655	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	23,508	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	12,485	0		59.00
60.00	06000	LABORATORY	146,728	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	61,924	0		63.00
65.00	06500	RESPIRATORY THERAPY	8,561	0		65.00
66.00	06600	PHYSICAL THERAPY	50,327	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	9,475	0		67.00
68.00	06800	SPEECH PATHOLOGY	17,946	0		68.00
69.00	06900	ELECTROCARDIOLOGY	42,605	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	725,143	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	44,078	0		76.00
76.01	03340	GASTRO INTESTINAL SERVICES	18,766	0		76.01
76.02	03550	OP PSYCH	0	0		76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	407,444	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	123,550	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	252,209			95.00
200.00		Subtotal (see instructions)	2,447,952	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	2,447,952	0		202.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018

Worksheet D-1

Date/Time Prepared:
5/24/2019 2:49 pm

Title XVIII		Hospital	PPS
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	23,936	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	23,936	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)	21,778	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	9,507	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)	26,124,625	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)	26,124,625	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)	26,124,625	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)	1,091.44	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	10,376,320	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)	10,376,320	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018

Worksheet D-1

Date/Time Prepared:
5/24/2019 2:49 pm

		Title XVIII		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,728,791	2,321	2,037.39	1,066	2,171,858
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)					12,154,836
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					24,703,014
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,207,253
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					942,984
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,150,237
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					22,552,777
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)					2,158
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,091.44
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,355,328

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018

Worksheet D-1

Date/Time Prepared:
5/24/2019 2:49 pm

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	2,657,828	26,124,625	0.101737	2,355,328	239,624	90.00
91.00 Nursing School cost	0	26,124,625	0.000000	2,355,328	0	91.00
92.00 Allied health cost	0	26,124,625	0.000000	2,355,328	0	92.00
93.00 All other Medical Education	0	26,124,625	0.000000	2,355,328	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0002 Component CCN: 14-S002	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/24/2019 2:49 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,726	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,726	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)		2,726	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)		1,939	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)		2,982,523	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)		2,982,523	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)		2,982,523	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)		1,094.10	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,121,460	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)		2,121,460	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0002	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1
			Component CCN: 14-S002		Date/Time Prepared: 5/24/2019 2:49 pm
			Title XVIII	Subprovider - IPF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					146,869 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,268,329 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)					190,022 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					13,531 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					203,553 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,064,776 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: 14-0002 Component CCN: 14-S002		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/24/2019 2:49 pm	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
			1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	267,143	2,982,523	0.089569	0	0	90.00	
91.00	Nursing School cost	0	2,982,523	0.000000	0	0	91.00	
92.00	Allied health cost	0	2,982,523	0.000000	0	0	92.00	
93.00	All other Medical Education	0	2,982,523	0.000000	0	0	93.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0002	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/24/2019 2:49 pm	
		Title XIX	Hospital	PPS	
Cost Center Description				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			23,936	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			23,936	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)			21,778	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)			1,733	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)			26,124,625	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)			26,124,625	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)			26,124,625	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)			1,091.44	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,891,466	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			1,891,466	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018

Worksheet D-1

Date/Time Prepared:
5/24/2019 2:49 pm

		Title XIX		Hospital		PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	4,728,791	2,321	2,037.39	77	156,879	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)					552,926	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,601,271	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)					203,382	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					50,316	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					253,698	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,347,573	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					2,158	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,091.44	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,355,328	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018

Worksheet D-1

Date/Time Prepared:
5/24/2019 2:49 pm

Cost Center Description		Title XIX		Hospital	PPS	
		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	2,657,828	26,124,625	0.101737	2,355,328	239,624
91.00	Nursing School cost	0	26,124,625	0.000000	2,355,328	0
92.00	Allied health cost	0	26,124,625	0.000000	2,355,328	0
93.00	All other Medical Education	0	26,124,625	0.000000	2,355,328	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0002	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/24/2019 2:49 pm	
Cost Center Description		Title XVIII	Hospital	PPS	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		19,961,376	30.00
31.00	03100	INTENSIVE CARE UNIT		4,759,612	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.282090	5,092,010	50.00
51.00	05100	RECOVERY ROOM	0.195206	676,709	51.00
53.00	05300	ANESTHESIOLOGY	0.038189	1,788,662	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.156091	2,029,310	54.00
56.00	05600	RADIOISOTOPE	0.236250	345,873	56.00
57.00	05700	CT SCAN	0.026409	5,531,199	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.095050	631,764	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.162857	676,296	59.00
60.00	06000	LABORATORY	0.127799	9,852,601	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.280970	555,170	63.00
65.00	06500	RESPIRATORY THERAPY	0.318092	2,643,647	65.00
66.00	06600	PHYSICAL THERAPY	0.297785	785,949	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.377080	388,992	67.00
68.00	06800	SPEECH PATHOLOGY	0.340997	93,511	68.00
69.00	06900	ELECTROCARDIOLOGY	0.091404	6,018,077	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.347136	2,479,449	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.393107	5,469,025	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.455915	5,387,127	73.00
74.00	07400	RENAL DIALYSIS	0.467028	708,920	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0.290383	1,071	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0.283048	447,922	76.01
76.02	03550	OP PSYCH	0.458024	1,863	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.112541	0	76.98
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.094170	5,415,295	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.669218	222,446	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		57,242,888	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		57,242,888	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0002 Component CCN: 14-S002	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/24/2019 2:49 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		3,916,944		40.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.282090	0	0	50.00
51.00	05100 RECOVERY ROOM	0.195206	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.038189	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.156091	53,943	8,420	54.00
56.00	05600 RADIOISOTOPE	0.236250	0	0	56.00
57.00	05700 CT SCAN	0.026409	200,369	5,292	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.095050	2,303	219	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.162857	48,801	7,948	59.00
60.00	06000 LABORATORY	0.127799	317,366	40,559	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.280970	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.318092	11,055	3,517	65.00
66.00	06600 PHYSICAL THERAPY	0.297785	24,570	7,317	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.377080	7,035	2,653	67.00
68.00	06800 SPEECH PATHOLOGY	0.340997	9,481	3,233	68.00
69.00	06900 ELECTROCARDIOLOGY	0.091404	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.347136	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.393107	62	24	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.455915	90,894	41,440	73.00
74.00	07400 RENAL DIALYSIS	0.467028	0	0	74.00
76.00	03020 ONCOLOGY & PAIN MANAGEMENT	0.290383	771	224	76.00
76.01	03340 GASTRO INTESTINAL SERVICES	0.283048	0	0	76.01
76.02	03550 OP PSYCH	0.458024	752	344	76.02
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.112541	0	0	76.98
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.094170	272,686	25,679	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.669218	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,040,088	146,869	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		1,040,088		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0002	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/24/2019 2:49 pm	
		Title XIX	Hospital	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		2,355,359	30.00
31.00	03100	INTENSIVE CARE UNIT		335,994	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.282090	483,483	50.00
51.00	05100	RECOVERY ROOM	0.195206	39,865	51.00
53.00	05300	ANESTHESIOLOGY	0.038189	101,976	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.156091	129,303	54.00
56.00	05600	RADIOISOTOPE	0.236250	12,593	56.00
57.00	05700	CT SCAN	0.026409	286,413	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.095050	33,274	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.162857	94,164	59.00
60.00	06000	LABORATORY	0.127799	715,413	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.280970	134,191	63.00
65.00	06500	RESPIRATORY THERAPY	0.318092	129,932	65.00
66.00	06600	PHYSICAL THERAPY	0.297785	15,041	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.377080	6,912	67.00
68.00	06800	SPEECH PATHOLOGY	0.340997	1,591	68.00
69.00	06900	ELECTROCARDIOLOGY	0.091404	265,061	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.347136	16,414	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.393107	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.455915	209,640	73.00
74.00	07400	RENAL DIALYSIS	0.467028	15,106	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0.290383	0	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0.283048	10,795	76.01
76.02	03550	OP PSYCH	0.458024	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.112541	0	76.98
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.094170	445,348	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.669218	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,146,515	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		3,146,515	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet E
Part A
Date/Time Prepared:
5/24/2019 2:49 pm

		Title XVIII	Hospital	PPS	
				1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			14,678,100	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			5,036,106	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)			0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)			0	1.04
2.00	Outlier payments for discharges. (see instructions)			251,686	2.00
2.01	Outlier reconciliation amount			0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)			0	2.02
3.00	Managed Care Simulated Payments			8,163,997	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			126.09	4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)			0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).			0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)			0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)			0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.			0.00	11.00
12.00	Current year allowable FTE (see instructions)			0.00	12.00
13.00	Total allowable FTE count for the prior year.			0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.			0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.			0.00	15.00
16.00	Adjustment for residents in initial years of the program			0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure			0.00	17.00
18.00	Adjusted rolling average FTE count			0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	21.00
22.00	IME payment adjustment (see instructions)			0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).			0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)			0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)			0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)			0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)			0	28.01
29.00	Total IME payment (sum of lines 22 and 28)			0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			4.33	30.00
31.00	Percentage of Medicaid patient days (see instructions)			18.13	31.00
32.00	Sum of lines 30 and 31			22.46	32.00
33.00	Allowable disproportionate share percentage (see instructions)			7.74	33.00
34.00	Disproportionate share adjustment (see instructions)			381,470	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0002	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/24/2019 2:49 pm	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	819,044	996,370		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	612,600	251,140		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	863,740			36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00			45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)	21,211,102			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)		21,211,102		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,700,051		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
54.01	Islet isolation add-on payment		0		54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		22,911,153		59.00
60.00	Primary payer payments		7,552		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		22,903,601		61.00
62.00	Deductibles billed to program beneficiaries		2,459,520		62.00
63.00	Coinurance billed to program beneficiaries		64,655		63.00
64.00	Allowable bad debts (see instructions)		726,174		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		472,013		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		482,161		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		20,851,439		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0		70.50
70.87	Demonstration payment adjustment amount before sequestration		0		70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0		70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		29,484		70.93
70.94	HRR adjustment amount (see instructions)		-397,423		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0002	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/24/2019 2:49 pm	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96	
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97	
70.98	Low Volume Payment-3		0	70.98	
70.99	HAC adjustment amount (see instructions)		0	70.99	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		20,483,500	71.00	
71.01	Sequestration adjustment (see instructions)		409,670	71.01	
71.02	Demonstration payment adjustment amount after sequestration		0	71.02	
72.00	Interim payments		20,060,717	72.00	
73.00	Tentative settlement (for contractor use only)		0	73.00	
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		13,113	74.00	
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,190,975	75.00	
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00	
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00	
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00	
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00	
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00	
95.00	Time value of money for operating expenses (see instructions)		0	95.00	
96.00	Time value of money for capital related expenses (see instructions)		0	96.00	
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	100.00	
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00	
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00	
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00	
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00	
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00	
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00	
202.00	Medicare discharges (see instructions)			202.00	
203.00	Case-mix adjustment factor (see instructions)			203.00	
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount			204.00	
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00	
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00	
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00	
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00	
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00	
210.00	Reserved for future use			210.00	
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00	
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00	
213.00	Low-volume adjustment (see instructions)			213.00	
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00	

CALCULATION OF DSH PAYMENT PERCENTAGE

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018

Worksheet DSH

Date/Time Prepared:
5/24/2019 2:49 pm

		Title XVIII		Hospital		PPS	
		Original .mcrcx Values	Adjusted .mcrcx Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF THE DSH PAYMENT PERCENTAGE							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	4.33	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	18.13	0.00			18.13	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	22.46	0.00			18.13	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	Urban				Urban	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	126.09	0.00			126.09	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	7.74	0.00			0.00	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	Yes				No	9.00
10.00	S-2, Line 45	Yes				Yes	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	4.33	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	No				No	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	14.00
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	704	0			704	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	1,071	0			1,071	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	27	0			27	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	8	0			8	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	2,559	0			2,559	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	0	0			0	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	4,369	0			4,369	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	24,099	0			24,099	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	0	0			0	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	24,099	0			24,099	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	18.13	0.00			18.13	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE			Provider CCN: 14-0002		Period: From 01/01/2018 To 12/31/2018		Worksheet DSH Date/Time Prepared: 5/24/2019 2:49 pm	
			Title XVIII		Hospital		PPS	
			Original .mcrx Values		Adjusted .mcax Values		Revised	
			Condition	Percentage	Condition	Percentage	Condition	
			1.00	2.00	3.00	4.00	5.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE								
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	7.74		0.00	False	28.00	
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	True	29.00	
30.00	Line 28 or 29 as applicable		7.74		0.00		30.00	
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		7.74		0.00		31.00	
			Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
			1.00	2.00	3.00	4.00	5.00	
DETERMINATION OF PROVIDER TYPE								
32.00	Does the hospital qualify under the Pickle ammendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00	
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00	
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00	
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00	
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban				Urban	36.00	

CALCULATION OF DSH PAYMENT PERCENTAGE

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018

Worksheet DSH

Date/Time Prepared:
5/24/2019 2:49 pm

Title XVIII

Hospital

PPS

		Revised		
		Percentage		
		6.00		
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE			
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	0.00		28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	4.53		29.00
30.00	Line 28 or 29 as applicable	4.53		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	0.00		31.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0002	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/24/2019 2:49 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		10,425	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		21,491,648	2.00
3.00	OPPS payments		17,460,737	3.00
4.00	Outlier payment (see instructions)		44,173	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		10,425	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		23,288	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)		23,288	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		23,288	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		12,863	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)		10,425	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)		17,504,910	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		117	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		3,183,945	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)		14,331,273	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)		14,331,273	30.00
31.00	Primary payer payments		2,686	31.00
32.00	Subtotal (line 30 minus line 31)		14,328,587	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)		665,182	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		432,368	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		456,883	36.00
37.00	Subtotal (see instructions)		14,760,955	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)		14,760,955	40.00
40.01	Sequestration adjustment (see instructions)		295,219	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		14,425,983	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		39,753	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0002	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/24/2019 2:49 pm
	Title XVIII	Hospital	PPS
			Overrides
			1.00
WORKSHEET OVERRIDE VALUES			
112.00	Override of Ancillary service charges (line 12)		0112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet E-1
Part I
Date/Time Prepared:
5/24/2019 2:49 pm

		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		20,060,717		14,425,983	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		20,060,717		14,425,983	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		13,113		39,753	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		20,073,830		14,465,736	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 14-0002 Component CCN: 14-S002		Period: From 01/01/2018 To 12/31/2018		Worksheet E-1 Part I Date/Time Prepared: 5/24/2019 2:49 pm	
		Title XVIII		Subprovider - IPF		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					0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1,598,991			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0			0	3.01
3.02			0			0	3.02
3.03			0			0	3.03
3.04			0			0	3.04
3.05			0			0	3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0			0	3.50
3.51			0			0	3.51
3.52			0			0	3.52
3.53			0			0	3.53
3.54			0			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,598,991			0	4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0			0	5.01
5.02			0			0	5.02
5.03			0			0	5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0			0	5.50
5.51			0			0	5.51
5.52			0			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0			0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		39,112			0	6.01
6.02	SETTLEMENT TO PROGRAM		0			0	6.02
7.00	Total Medicare program liability (see instructions)		1,638,103			0	7.00
				Contractor Number		NPR Date (Mo/Day/Yr)	
		0		1.00		2.00	
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet E-1
Part II
Date/Time Prepared:
5/24/2019 2:49 pm

		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0002 Component CCN: 14-S002	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part II Date/Time Prepared: 5/24/2019 2:49 pm
		Title XVIII	Subprovider - IPF	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)			1,752,539 1.00
2.00	Net IPF PPS Outlier Payments			6,677 2.00
3.00	Net IPF PPS ECT Payments			0 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)			7.468493 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1)\}$.			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)			1,759,216 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)			1,759,216 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			1,759,216 18.00
19.00	Deductibles			123,232 19.00
20.00	Subtotal (line 18 minus line 19)			1,635,984 20.00
21.00	Coinurance			4,355 21.00
22.00	Subtotal (line 20 minus line 21)			1,631,629 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			61,393 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			39,905 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			29,168 25.00
26.00	Subtotal (sum of lines 22 and 24)			1,671,534 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)			0 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)			1,671,534 31.00
31.01	Sequestration adjustment (see instructions)			33,431 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			1,598,991 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)			39,112 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			6,677 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

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

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018

Worksheet G

Date/Time Prepared:
5/24/2019 2:49 pm

		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	370,138	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	24,274,453	0	0	0	4.00
5.00	Other receivable	1,987,737	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,524,882	0	0	0	6.00
7.00	Inventory	2,112,545	0	0	0	7.00
8.00	Prepaid expenses	424,902	0	0	0	8.00
9.00	Other current assets	29,650	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)	25,674,543	0	0	0	11.00
FIXED ASSETS						
12.00	Land	177,168	0	0	0	12.00
13.00	Land improvements	5,102,571	0	0	0	13.00
14.00	Accumulated depreciation	-4,403,269	0	0	0	14.00
15.00	Buildings	135,501,867	0	0	0	15.00
16.00	Accumulated depreciation	-82,447,154	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	1,036,531	0	0	0	19.00
20.00	Accumulated depreciation	-855,939	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	50,148,417	0	0	0	23.00
24.00	Accumulated depreciation	-40,548,091	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	1,989,420	0	0	0	27.00
28.00	Accumulated depreciation	-1,367,905	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)	64,333,616	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	90,008,159	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,580,878	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,806,543	0	0	0	38.00
39.00	Payroll taxes payable	1,177,389	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	4,913,199	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	11,478,009	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	321,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	321,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	11,799,009	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	78,209,150				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)	78,209,150	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	90,008,159	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018

Worksheet G-1

Date/Time Prepared:
5/24/2019 2:49 pm

		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		72,327,858		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-5,672,854				2.00
3.00	Total (sum of line 1 and line 2)		66,655,004		0		3.00
4.00	TRANSFER FRPM BJC	11,460,717		0		0	4.00
5.00	ASSETS RELEASD FROM RESTRICTED CAPIT	137,950		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)		11,598,667		0		10.00
11.00	Subtotal (line 3 plus line 10)		78,253,671		0		11.00
12.00	CHANGE IN RESTRICTED ASSETS	44,521		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)		44,521		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		78,209,150		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	TRANSFER FRPM BJC		0				4.00
5.00	ASSETS RELEASD FROM RESTRICTED CAPIT		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	CHANGE IN RESTRICTED ASSETS		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: 14-0002

Period:
From 01/01/2018
To 12/31/2018Worksheet G-2
Parts I & II
Date/Time Prepared:
5/24/2019 2:49 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	47,693,794		47,693,794	1.00
2.00	SUBPROVIDER - IPF	5,556,608		5,556,608	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)	53,250,402		53,250,402	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	9,965,744		9,965,744	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)	9,965,744		9,965,744	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	63,216,146		63,216,146	17.00
18.00	Ancillary services	118,590,922	0	118,590,922	18.00
19.00	Outpatient services	0	321,441,109	321,441,109	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	17,340	17,757,190	17,774,530	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	181,824,408	339,198,299	521,022,707	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		139,819,855		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	NON OPERATING EXPENSES	2,006,692			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)		2,006,692		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		137,813,163		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0002

Period:
From 01/01/2018
To 12/31/2018

Worksheet G-3

Date/Time Prepared:
5/24/2019 2:49 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	521,022,707	1.00
2.00	Less contractual allowances and discounts on patients' accounts	382,724,970	2.00
3.00	Net patient revenues (line 1 minus line 2)	138,297,737	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	137,813,163	4.00
5.00	Net income from service to patients (line 3 minus line 4)	484,574	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	152,467	6.00
7.00	Income from investments	549,336	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	804,898	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MEANINGFUL USE MEDICARE	1,930	24.00
24.01	BJC OTHER OPERATING REVENUE	82,975	24.01
24.02	SHARED SAVINGS MEDICARE	375,829	24.02
24.03	EUNICE SMITH NET INCOME	407,293	24.03
24.04	POB NET INCOME	141,122	24.04
24.05	OTHER OPERATING REVENUE	1,634,909	24.05
25.00	Total other income (sum of lines 6-24)	4,150,759	25.00
26.00	Total (line 5 plus line 25)	4,635,333	26.00
27.00	PHYSICIAN PRACTICE OPERATIONS	10,308,187	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	10,308,187	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-5,672,854	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0002	Period: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III Date/Time Prepared: 5/24/2019 2:49 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,593,086	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		32,727	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		66.02	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		4.33	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		18.13	8.00
9.00	Sum of lines 7 and 8		22.46	9.00
10.00	Allowable disproportionate share percentage (see instructions)		4.66	10.00
11.00	Disproportionate share adjustment (see instructions)		74,238	11.00
12.00	Total prospective capital payments (see instructions)		1,700,051	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00