

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: 14-0043	Period: From 05/01/2017 To 04/30/2018	Worksheet S Parts I-III Date/Time Prepared: 9/24/2018 2:23 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 9/24/2018	Time: 2:23 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 CGH MEDICAL CENTER (14-0043) for the cost reporting period beginning 05/01/2017 and ending 04/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) BEN SCHAAB

Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-66,510	95,926	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	-66,510	95,926	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: 14-0043

Period:
From 05/01/2017
To 04/30/2018Worksheet S-2
Part I
Date/Time Prepared:
9/24/2018 11:56 am

1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 100 EAST LEFEVRE ROAD			PO Box:				1.00	
2.00	City: STERLING			State: IL		Zip Code: 61081-1279		County: WHITESIDE 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	CGH MEDICAL CENTER	140043	99914	1	07/01/1966	N	P	N
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF	CGH MEDICAL CENTER	14U043	99914		01/13/2004	N	P	N
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA	CGH HOME NURSING	147562	99914		05/05/1994	N	P	N
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
						From:	To:		
						1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)					05/01/2017	04/30/2018		20.00
21.00	Type of Control (see instructions)					12			21.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N		23.00
			In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
			1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.		1,746	502	0	0	107	103	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.		0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0043	Period: From 05/01/2017 To 04/30/2018	Worksheet S-2 Part I Date/Time Prepared: 9/24/2018 11:56 am	
			Urban/Rural S	Date of Geogr	
			1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.		2		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.		2		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.		1		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.		05/01/2017	04/30/2018	38.00
			Y/N	Y/N	
			1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)		N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)		N	N	40.00
			V	XVIII	XIX
			1.00	2.00	3.00
Prospective Payment System (PPS)-Capital					
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)		N	N	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.		N		
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		
			Y/N	IME	Direct GME
			1.00	2.00	3.00
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			
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)				
61.02	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)				
61.03	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)				

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

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

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				1.00	
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?		N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		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	
			1.00	2.00	
			Speech	Respiratory	
			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	109.00
				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0043	Period: From 05/01/2017 To 04/30/2018	Worksheet S-2 Part I Date/Time Prepared: 9/24/2018 11:56 am	
			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
			1.00	2.00	3.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	652,942	0	0	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N			140.00

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1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?					Y	144.00
						1.00	
						2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				Y	145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N	146.00	
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					N	149.00
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.					Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)						168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					0.00	169.00
				Beginning	Ending		
				1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			07/01/2017	09/30/2017	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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

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		Y/N	Date	
		1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	07/25/2018
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
		Y/N	Legal Oper.	
		1.00	2.00	
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
		Y/N		
		1.00		
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Part A		Part B
		Y/N	Date	Y/N
		1.00	2.00	3.00
		4.00		
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	08/01/2018	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		N
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

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		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		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.		N		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.	KEVIN	WELLEN		41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSENALLEN LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4446	KEVIN.WELLEN@CLACONNECT.COM		43.00

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		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HFS Supplemental Information

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Part IX
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		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

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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	84	30,660	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)		84	30,660	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	9	3,285	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		93	33,945	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	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)		93			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

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Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	6,769	1,273	11,617			1.00
2.00	HMO and other (see instructions)	940	609				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	6,769	1,273	11,617			7.00
8.00	INTENSIVE CARE UNIT	768	49	1,189			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		424	1,016			13.00
14.00	Total (see instructions)	7,537	1,746	13,822	0.00	1,316.66	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	2,606	0	6,677	0.00	14.34	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	1,331.00	27.00
28.00	Observation Bed Days		0	2,905			28.00
29.00	Ambulance Trips	2,438					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	103	194			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: 14-0043

Period:
From 05/01/2017
To 04/30/2018Worksheet S-3
Part I
Date/Time Prepared:
9/24/2018 11:56 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	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	2,096	542	4,079	1.00
2.00 HMO and other (see instructions)			250	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	2,096	542	4,079	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					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: 14-0043

Period:
From 05/01/2017
To 04/30/2018Worksheet S-3
Part II
Date/Time Prepared:
9/24/2018 11:56 am

		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	96,243,348	0	96,243,348	2,768,486.00	34.76	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		2,103,247	0	2,103,247	14,029.00	149.92	3.00
4.00	Physician-Part A - Administrative		161,838	0	161,838	1,059.00	152.82	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		29,493,419	0	29,493,419	170,277.00	173.21	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		7,671,434	0	7,671,434	248,092.00	30.92	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		629,019	0	629,019	11,064.50	56.85	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		3,000	0	3,000	20.00	150.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		25,550,985	0	25,550,985			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		2,953,363	0	2,953,363			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		361,588	0	361,588			21.00
22.00	Physician Part A - Administrative		21,178	0	21,178			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		3,714,408	0	3,714,408			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	564,550	0	564,550	16,525.00	34.16	26.00
27.00	Administrative & General	5.00	13,200,361	-582,231	12,618,130	441,930.00	28.55	27.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018Worksheet S-3
Part II
Date/Time Prepared:
9/24/2018 11:56 am

		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.)		173,224	0	173,224	982.11	176.38	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,154,427	0	1,154,427	56,490.00	20.44	30.00
31.00	Laundry & Linen Service	8.00	261,142	0	261,142	22,695.00	11.51	31.00
32.00	Housekeeping	9.00	1,074,333	0	1,074,333	81,539.00	13.18	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	981,973	-805,482	176,491	11,709.00	15.07	34.00
35.00	Dietary under contract (see instructions)		27,513	0	27,513	500.34	54.99	35.00
36.00	Cafeteria	11.00	0	805,482	805,482	53,436.00	15.07	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	926,006	-353,625	572,381	7,059.00	81.09	38.00
39.00	Central Services and Supply	14.00	565,607	0	565,607	26,920.00	21.01	39.00
40.00	Pharmacy	15.00	1,220,092	-1,220,092	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	1,985,279	0	1,985,279	93,863.00	21.15	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018Worksheet S-3
Part III
Date/Time Prepared:
9/24/2018 11:56 am

	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)	64,847,419	0	64,847,419	2,585,662.45	25.08	1.00
2.00	Excluded area salaries (see instructions)	7,671,434	0	7,671,434	248,092.00	30.92	2.00
3.00	Subtotal salaries (line 1 minus line 2)	57,175,985	0	57,175,985	2,337,570.45	24.46	3.00
4.00	Subtotal other wages & related costs (see inst.)	632,019	0	632,019	11,084.50	57.02	4.00
5.00	Subtotal wage-related costs (see inst.)	25,572,163	0	25,572,163	0.00	44.73	5.00
6.00	Total (sum of lines 3 thru 5)	83,380,167	0	83,380,167	2,348,654.95	35.50	6.00
7.00	Total overhead cost (see instructions)	22,134,507	-2,155,948	19,978,559	813,648.45	24.55	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018Worksheet S-3
Part IV
Date/Time Prepared:
9/24/2018 11:56 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	3,407,531	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)	5,213,594	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)	17,269,257	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	195,471	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	313,234	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	1,458	16.00
TAXES			
17.00	FICA-Employers Portion Only	4,422,804	17.00
18.00	Medicare Taxes - Employers Portion Only	1,358,009	18.00
19.00	Unemployment Insurance	35,659	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	384,505	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	32,601,522	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: 14-0043

Period:
From 05/01/2017
To 04/30/2018Worksheet S-3
Part V
Date/Time Prepared:
9/24/2018 11:56 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	690,492	32,601,522	1.00
2.00	Hospital	629,019	32,204,122	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	61,473	397,400	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

Health Financial Systems		CGH MEDICAL CENTER		In Lieu of Form CMS-2552-10		
HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 14-0043 Component CCN: 14-7562		Period: From 05/01/2017 To 04/30/2018 Worksheet S-4 Date/Time Prepared: 9/24/2018 11:56 am		
				Home Health Agency I PPS		
				1.00		
0.00 County				WHITESIDE		
		Title V	Title XVIII	Title XIX	Other	Total
		1.00	2.00	3.00	4.00	5.00
HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	184	0	1,914	2,098
2.00	Unduplicated Census Count (see instructions)	0.00	230.00	0.00	297.00	527.00
				Number of Employees (Full Time Equivalent)		
		Enter the number of hours in your normal work week		Staff	Contract	Total
		0		1.00	2.00	3.00
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)	40.00		1.75	0.00	1.75
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00
5.00	Other Administrative Personnel			0.00	0.00	0.00
6.00	Direct Nursing Service			9.66	0.00	9.66
7.00	Nursing Supervisor			0.00	0.00	0.00
8.00	Physical Therapy Service			1.88	0.22	2.10
9.00	Physical Therapy Supervisor			0.00	0.00	0.00
10.00	Occupational Therapy Service			0.00	0.04	0.04
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00
12.00	Speech Pathology Service			0.05	0.00	0.05
13.00	Speech Pathology Supervisor			0.00	0.00	0.00
14.00	Medical Social Service			0.00	0.00	0.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00
16.00	Home Health Aide			1.01	0.00	1.01
17.00	Home Health Aide Supervisor			0.00	0.00	0.00
18.00	Other (specify)			0.00	0.00	0.00
HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1		
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99914		
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)
		Without Outliers	With Outliers			
		1.00	2.00	3.00	4.00	5.00
PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,152	146	153	24	1,475
22.00	Skilled Nursing Visit Charges	224,640	28,470	29,835	4,680	287,625
23.00	Physical Therapy Visits	782	24	26	15	847
24.00	Physical Therapy Visit Charges	143,106	4,384	4,758	2,745	154,993
25.00	Occupational Therapy Visits	28	10	2	10	50
26.00	Occupational Therapy Visit Charges	4,900	1,750	350	1,750	8,750
27.00	Speech Pathology Visits	46	0	0	4	50
28.00	Speech Pathology Visit Charges	8,510	0	0	740	9,250
29.00	Medical Social Service Visits	0	0	0	0	0
30.00	Medical Social Service Visit Charges	0	0	0	0	0
31.00	Home Health Aide Visits	124	53	3	4	184
32.00	Home Health Aide Visit Charges	10,455	4,505	255	340	15,555
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,132	233	184	57	2,606
34.00	Other Charges	0	0	0	0	0
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	391,611	39,109	35,198	10,255	476,173
36.00	Total Number of Episodes (standard/non outlier)	208		60	2	270
37.00	Total Number of Outlier Episodes		8		2	10
38.00	Total Non-Routine Medical Supply Charges	5,434	251	3,178	0	8,863

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0043	Period: From 05/01/2017 To 04/30/2018	Worksheet S-10 Date/Time Prepared: 9/24/2018 11:56 am
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.229370 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	6,444,524		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	8,507,455		5.00
6.00	Medicaid charges	92,088,002		6.00
7.00	Medicaid cost (line 1 times line 6)	21,122,225		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)	6,170,246		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP	92,641		9.00
10.00	Stand-alone CHIP charges	1,125,367		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	258,125		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	165,484		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)	6,335,730		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	4,225,093	870,383	5,095,476 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	969,110	870,383	1,839,493 21.00
22.00	Payments received from patients for amounts previously written off as charity care	86,192	0	86,192 22.00
23.00	Cost of charity care (line 21 minus line 22)	882,918	870,383	1,753,301 23.00
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	10,286,391		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	955,982		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,470,741		27.01
28.00	Non-Medicare bad debt expense (see instructions)	8,815,650		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,536,805		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	4,290,106		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	10,625,836		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018

Worksheet A

Date/Time Prepared:
9/24/2018 11:56 am

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	CAP REL COSTS-BLDG & FIXT		11,112,367	11,112,367	-5,378,948	5,733,419	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	7,289,622	7,289,622	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	564,550	32,579,993	33,144,543	-1,013	33,143,530	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,200,361	11,862,549	25,062,910	-401,416	24,661,494	5.00
7.00	00700	OPERATION OF PLANT	1,154,427	2,680,145	3,834,572	35,608	3,870,180	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	261,142	153,661	414,803	0	414,803	8.00
9.00	00900	HOUSEKEEPING	1,074,333	1,152,473	2,226,806	-9,347	2,217,459	9.00
10.00	01000	DIETARY	981,973	1,015,195	1,997,168	-1,640,676	356,492	10.00
11.00	01100	CAFETERIA	0	0	0	1,638,215	1,638,215	11.00
13.00	01300	NURSING ADMINISTRATION	926,006	221,674	1,147,680	-357,264	790,416	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	565,607	394,748	960,355	-273,209	687,146	14.00
15.00	01500	PHARMACY	1,220,092	8,906,690	10,126,782	-9,796,272	330,510	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,985,279	874,844	2,860,123	-403	2,859,720	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,391,493	1,423,011	11,814,504	-674,527	11,139,977	30.00
31.00	03100	INTENSIVE CARE UNIT	2,261,268	478,204	2,739,472	-943,436	1,796,036	31.00
43.00	04300	NURSERY	0	0	0	467,213	467,213	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,684,190	5,930,716	7,614,906	-5,575,611	2,039,295	50.00
51.00	05100	RECOVERY ROOM	937,722	301,181	1,238,903	-258,776	980,127	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	906,937	906,937	52.00
53.00	05300	ANESTHESIOLOGY	2,103,247	787,688	2,890,935	-513,652	2,377,283	53.00
53.01	05301	PAIN MANAGEMENT	964,013	85,670	1,049,683	-56,637	993,046	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,192,428	1,944,672	3,137,100	222,630	3,359,730	54.00
54.01	05401	ULTRASOUND	374,046	799,133	1,173,179	48,815	1,221,994	54.01
56.00	05600	RADIOISOTOPE	243,302	1,065,111	1,308,413	-857,974	450,439	56.00
57.00	05700	CT SCAN	536,254	2,100,595	2,636,849	-40,623	2,596,226	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	345,586	792,212	1,137,798	10,809	1,148,607	58.00
59.00	05900	CARDIAC CATHETERIZATION	672,633	1,721,183	2,393,816	-1,313,743	1,080,073	59.00
60.00	06000	LABORATORY	2,617,468	4,584,879	7,202,347	-1,655,761	5,546,586	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	862,360	226,820	1,089,180	-170,137	919,043	65.00
66.00	06600	PHYSICAL THERAPY	362,017	11,716	373,733	-4,424	369,309	66.00
67.00	06700	OCCUPATIONAL THERAPY	78,900	5,913	84,813	-2,378	82,435	67.00
68.00	06800	SPEECH PATHOLOGY	178,772	11,940	190,712	-2,150	188,562	68.00
69.00	06900	ELECTROCARDIOLOGY	842,534	139,147	981,681	-51,197	930,484	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	251,107	46,827	297,934	-40,465	257,469	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	13,985,271	13,985,271	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	22,955,122	22,955,122	73.00
74.00	07400	RENAL DIALYSIS	0	198,192	198,192	-742	197,450	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	GI LAB	994,964	1,122,184	2,117,148	-963,181	1,153,967	75.01
76.00	03950	DIABETIC EDUCATION	223,277	56,629	279,906	-4,977	274,929	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	611,770	980,785	1,592,555	-394,393	1,198,162	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	34,542,645	16,548,644	51,091,289	-13,613,350	37,477,939	90.00
91.00	09100	EMERGENCY	3,366,148	5,350,051	8,716,199	-466,152	8,250,047	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,410,218	297,506	1,707,724	-147,413	1,560,311	95.00
98.00	09850	HOME INFUSION	62,327	85,665	147,992	-22,526	125,466	98.00
101.00	10100	HOME HEALTH AGENCY	1,032,256	224,646	1,256,902	-36,759	1,220,143	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		448,053	448,053	-448,053	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	91,076,715	118,723,312	209,800,027	1,442,657	211,242,684	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	22,833	40,483	63,316	0	63,316	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,467,924	991,723	4,459,647	-14,698	4,444,949	192.00
194.00	07950	COMMUNITY SERVICE	263,066	106,575	369,641	-3,996	365,645	194.00
194.01	07951	OFFSITE FREESTANDING PT/OT	1,412,810	89,234	1,502,044	0	1,502,044	194.01
194.02	07952	OFFSITE BUILDINGS	0	1,565,071	1,565,071	-1,423,963	141,108	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	96,243,348	121,516,398	217,759,746	0	217,759,746	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018

Worksheet A

Date/Time Prepared:
9/24/2018 11:56 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-448,053	5,285,366	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-36,798	7,252,824	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-3,446,284	29,697,246	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,647,563	22,013,931	5.00
7.00	00700	OPERATION OF PLANT	-7,704	3,862,476	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-6,682	408,121	8.00
9.00	00900	HOUSEKEEPING	-417	2,217,042	9.00
10.00	01000	DIETARY	0	356,492	10.00
11.00	01100	CAFETERIA	-812,467	825,748	11.00
13.00	01300	NURSING ADMINISTRATION	0	790,416	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	687,146	14.00
15.00	01500	PHARMACY	-4,000	326,510	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-82,103	2,777,617	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,827,395	8,312,582	30.00
31.00	03100	INTENSIVE CARE UNIT	-50,293	1,745,743	31.00
43.00	04300	NURSERY	0	467,213	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	2,039,295	50.00
51.00	05100	RECOVERY ROOM	0	980,127	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	906,937	52.00
53.00	05300	ANESTHESIOLOGY	-2,337,534	39,749	53.00
53.01	05301	PAIN MANAGEMENT	-768,885	224,161	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,278,266	2,081,464	54.00
54.01	05401	ULTRASOUND	-532,201	689,793	54.01
56.00	05600	RADIOISOTOPE	-54,789	395,650	56.00
57.00	05700	CT SCAN	-1,723,862	872,364	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-580,805	567,802	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,080,073	59.00
60.00	06000	LABORATORY	-848,009	4,698,577	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	-2,972	916,071	65.00
66.00	06600	PHYSICAL THERAPY	0	369,309	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	82,435	67.00
68.00	06800	SPEECH PATHOLOGY	0	188,562	68.00
69.00	06900	ELECTROCARDIOLOGY	-13,570	916,914	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-1,300	256,169	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	13,985,271	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-2,082,823	20,872,299	73.00
74.00	07400	RENAL DIALYSIS	0	197,450	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
75.01	07501	GI LAB	0	1,153,967	75.01
76.00	03950	DIABETIC EDUCATION	0	274,929	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	-495,546	702,616	76.98
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-28,251,649	9,226,290	90.00
91.00	09100	EMERGENCY	-4,759,871	3,490,176	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-1,507	1,558,804	95.00
98.00	09850	HOME INFUSION	-1,261	124,205	98.00
101.00	10100	HOME HEALTH AGENCY	0	1,220,143	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-54,104,609	157,138,075	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	63,316	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,444,949	192.00
194.00	07950	COMMUNITY SERVICE	0	365,645	194.00
194.01	07951	OFFSITE FREESTANDING PT/OT	0	1,502,044	194.01
194.02	07952	OFFSITE BUILDINGS	0	141,108	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-54,104,609	163,655,137	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018Worksheet Non-CMS W
Date/Time Prepared:
9/24/2018 11:56 am

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
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
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
43.00	NURSERY	04300		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
53.01	PAIN MANAGEMENT	05301		53.01
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
54.01	ULTRASOUND	05401		54.01
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
64.00	INTRAVENOUS THERAPY	06400		64.00
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
70.00	ELECTROENCEPHALOGRAPHY	07000		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
74.00	RENAL DIALYSIS	07400		74.00
75.00	ASC (NON-DISTINCT PART)	07500		75.00
75.01	GI LAB	07501		75.01
76.00	DIABETIC EDUCATION	03950		76.00
76.98	HYPERBARIC OXYGEN THERAPY	07698		76.98
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	09000		90.00
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
98.00	HOME INFUSION	09850		98.00
101.00	HOME HEALTH AGENCY	10100		101.00
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)			118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
194.00	COMMUNITY SERVICE	07950		194.00
194.01	OFFSITE FREESTANDING PT/OT	07951		194.01
194.02	OFFSITE BUILDINGS	07952		194.02
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

RECLASSIFICATIONS

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018

Worksheet A-6

Date/Time Prepared:
9/24/2018 11:56 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	448,053		1.00
	0		0	448,053		
	B - L&D AND NURSERY COST					
1.00	NURSERY	43.00	436,217	19,218		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	846,771	37,305		2.00
	0		1,282,988	56,523		
	C - OFFSITE BLDG					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	171,514		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	748,814		2.00
3.00	OTHER CAP REL COSTS	3.00	0	18,236		3.00
4.00	OPERATION OF PLANT	7.00	0	500,812		4.00
5.00	OFFSITE BUILDINGS	194.02	0	6,066		5.00
6.00	OFFSITE BUILDINGS	194.02	0	9,347		6.00
	0		0	1,454,789		
	D - PHYSICIAN REMUNERATION					
1.00	ADMINISTRATIVE & GENERAL	5.00	15,000	0		1.00
	0		15,000	0		
	E - COLLECTIONS & BILLING EXP					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	63,139		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
	0		0	63,139		
	F - CAFETERIA EXPENSE					
1.00	CAFETERIA	11.00	805,482	832,733		1.00
	0		805,482	832,733		
	G - DRUG EXPENSE					
1.00	DRUGS CHARGED TO PATIENTS	73.00	1,220,092	21,735,030		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
	0		1,220,092	21,735,030		
	H - MARKETING & ADVERTISING					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	16,207		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
	0		0	16,207		
	I - TELEPHONE EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	130,316		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

RECLASSIFICATIONS

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018

Worksheet A-6

Date/Time Prepared:
9/24/2018 11:56 am

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
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
0			0	130,316	
J - PROPERTY INSURANCE & TAXES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00		336,048	1.00
2.00	OTHER CAP REL COSTS	3.00		194,075	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
0			0	530,123	
K - MALPRACTICE INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	17,450	1.00
2.00		0.00	0	0	2.00
0			0	17,450	
L - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	13,985,271	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
0			0	13,985,271	
N - POST ICU					
1.00	ADULTS & PEDIATRICS	30.00	781,143	93,337	1.00
0			781,143	93,337	
O - MME DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	7,197,999	1.00
0			0	7,197,999	
P - UTILITIES EXPENSE					
1.00	OPERATION OF PLANT	7.00	0	6,423	1.00
0			0	6,423	
Q - NURSE FLOATS & SHIFT COORDINATORS					
1.00	ADULTS & PEDIATRICS	30.00	272,543	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	46,443	0	2.00
3.00	NURSERY	43.00	11,778	0	3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	22,861	0	4.00
0			353,625	0	
R - RADIOLOGY MANAGEMENT					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	318,515	19,933	1.00
2.00	ULTRASOUND	54.01	68,306	4,275	2.00
3.00	RADIOISOTOPE	56.00	36,198	2,265	3.00

RECLASSIFICATIONS

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018

Worksheet A-6

Date/Time Prepared:
9/24/2018 11:56 am

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
4.00	CT SCAN	57.00	111,902	7,003	4.00
5.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	62,310	3,899	5.00
	0		597,231	37,375	
S - RADIOLOGY TECHS & PHLEBOTMIST					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	46,079	0	1.00
2.00	ULTRASOUND	54.01	151	0	2.00
3.00	LABORATORY	60.00	12,098	0	3.00
	0		58,328	0	
500.00	Grand Total: Increases		5,113,889	46,604,768	500.00

RECLASSIFICATIONS

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018

Worksheet A-6

Date/Time Prepared:
9/24/2018 11:56 am

	Decreases						9/24/2018 11:56 am
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	448,053	11		1.00
	0		0	448,053			
	B - L&D AND NURSERY COST						
1.00	ADULTS & PEDIATRICS	30.00	1,282,988	56,523	0		1.00
2.00		0.00	0	0	0		2.00
	0		1,282,988	56,523			
	C - OFFSITE BLDG						
1.00	HOUSEKEEPING	9.00	0	9,347	13		1.00
2.00	OFFSITE BUILDINGS	194.02	0	1,439,376	10		2.00
3.00	CAP REL COSTS-BLDG & FIXT	1.00	0	6,066	9		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	0		0	1,454,789			
	D - PHYSICIAN REMUNERATION						
1.00	CLINIC	90.00	15,000	0	0		1.00
	0		15,000	0			
	E - COLLECTIONS & BILLING EXP						
1.00	DIETARY	10.00	0	2,461	0		1.00
2.00	PHARMACY	15.00	0	8,454	0		2.00
3.00	AMBULANCE SERVICES	95.00	0	52,034	0		3.00
4.00	HOME INFUSION	98.00	0	3	0		4.00
5.00	HOME HEALTH AGENCY	101.00	0	187	0		5.00
	0		0	63,139			
	F - CAFETERIA EXPENSE						
1.00	DIETARY	10.00	805,482	832,733	0		1.00
	0		805,482	832,733			
	G - DRUG EXPENSE						
1.00	NURSING ADMINISTRATION	13.00	0	1,248	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	111	0		2.00
3.00	PHARMACY	15.00	1,220,092	8,466,844	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	11,855	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	3,127	0		5.00
6.00	RECOVERY ROOM	51.00	0	41,931	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	308,122	0		7.00
8.00	PAIN MANAGEMENT	53.01	0	2,079	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	6,413	0		9.00
10.00	ULTRASOUND	54.01	0	30	0		10.00
11.00	RADIOISOTOPE	56.00	0	252,934	0		11.00
12.00	CT SCAN	57.00	0	239	0		12.00
13.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	252	0		13.00
14.00	CARDIAC CATHETERIZATION	59.00	0	810	0		14.00
15.00	LABORATORY	60.00	0	360	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	1,336	0		16.00
17.00	ELECTROCARDIOLOGY	69.00	0	144	0		17.00
18.00	GI LAB	75.01	0	1,018	0		18.00
19.00	HYPERBARIC OXYGEN THERAPY	76.98	0	53,156	0		19.00
20.00	CLINIC	90.00	0	12,555,922	0		20.00
21.00	EMERGENCY	91.00	0	21,769	0		21.00
22.00	AMBULANCE SERVICES	95.00	0	5,330	0		22.00
	0		1,220,092	21,735,030			
	H - MARKETING & ADVERTISING						
1.00	NURSING ADMINISTRATION	13.00	0	2,234	0		1.00
2.00	PHARMACY	15.00	0	293	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	112	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,294	0		4.00
5.00	HYPERBARIC OXYGEN THERAPY	76.98	0	1,918	0		5.00
6.00	CLINIC	90.00	0	350	0		6.00
7.00	HOME INFUSION	98.00	0	693	0		7.00
8.00	HOME HEALTH AGENCY	101.00	0	1,311	0		8.00
9.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	5,002	0		9.00
	0		0	16,207			
	I - TELEPHONE EXPENSE						
1.00	OPERATION OF PLANT	7.00	0	995	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	157	0		2.00
3.00	PHARMACY	15.00	0	382	0		3.00
4.00	MEDICAL RECORDS & LIBRARY	16.00	0	403	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	7,499	0		5.00
6.00	OPERATING ROOM	50.00	0	7,889	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	6,001	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	497	0		8.00
9.00	LABORATORY	60.00	0	1,288	0		9.00

RECLASSIFICATIONS

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018

Worksheet A-6

Date/Time Prepared:
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Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
10.00	ELECTROCARDIOLOGY	69.00	0	378	0	10.00
11.00	GI LAB	75.01	0	618	0	11.00
12.00	HYPERBARIC OXYGEN THERAPY	76.98	0	560	0	12.00
13.00	CLINIC	90.00	0	78,151	0	13.00
14.00	EMERGENCY	91.00	0	450	0	14.00
15.00	AMBULANCE SERVICES	95.00	0	8,267	0	15.00
16.00	HOME HEALTH AGENCY	101.00	0	7,085	0	16.00
17.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	9,696	0	17.00
0			0	130,316		
J - PROPERTY INSURANCE & TAXES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	8,922	13	1.00
2.00	OPERATION OF PLANT	7.00	0	336,048	0	2.00
3.00	OPERATION OF PLANT	7.00	0	134,584	0	3.00
4.00	AMBULANCE SERVICES	95.00	0	29,073	0	4.00
5.00	HOME INFUSION	98.00	0	1,278	0	5.00
6.00	HOME HEALTH AGENCY	101.00	0	16,222	0	6.00
7.00	COMMUNITY SERVICE	194.00	0	3,996	0	7.00
0			0	530,123		
K - MALPRACTICE INSURANCE						
1.00	AMBULANCE SERVICES	95.00	0	17,200	0	1.00
2.00	HOME INFUSION	98.00	0	250	0	2.00
0			0	17,450		
L - MEDICAL SUPPLIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,013	0	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	273,098	0	2.00
3.00	PHARMACY	15.00	0	100,207	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	462,573	0	4.00
5.00	INTENSIVE CARE UNIT	31.00	0	112,272	0	5.00
6.00	OPERATING ROOM	50.00	0	5,567,722	0	6.00
7.00	RECOVERY ROOM	51.00	0	216,845	0	7.00
8.00	ANESTHESIOLOGY	53.00	0	199,529	0	8.00
9.00	PAIN MANAGEMENT	53.01	0	54,558	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	150,693	0	10.00
11.00	ULTRASOUND	54.01	0	23,887	0	11.00
12.00	RADIOISOTOPE	56.00	0	643,503	0	12.00
13.00	CT SCAN	57.00	0	159,289	0	13.00
14.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	55,148	0	14.00
15.00	CARDIAC CATHETERIZATION	59.00	0	1,312,933	0	15.00
16.00	LABORATORY	60.00	0	1,666,211	0	16.00
17.00	RESPIRATORY THERAPY	65.00	0	168,801	0	17.00
18.00	PHYSICAL THERAPY	66.00	0	4,424	0	18.00
19.00	OCCUPATIONAL THERAPY	67.00	0	2,378	0	19.00
20.00	SPEECH PATHOLOGY	68.00	0	2,150	0	20.00
21.00	ELECTROCARDIOLOGY	69.00	0	50,675	0	21.00
22.00	ELECTROENCEPHALOGRAPHY	70.00	0	40,465	0	22.00
23.00	RENAL DIALYSIS	74.00	0	742	0	23.00
24.00	GI LAB	75.01	0	961,545	0	24.00
25.00	DIABETIC EDUCATION	76.00	0	4,977	0	25.00
26.00	HYPERBARIC OXYGEN THERAPY	76.98	0	338,759	0	26.00
27.00	CLINIC	90.00	0	905,599	0	27.00
28.00	EMERGENCY	91.00	0	443,933	0	28.00
29.00	AMBULANCE SERVICES	95.00	0	29,086	0	29.00
30.00	HOME INFUSION	98.00	0	20,302	0	30.00
31.00	HOME HEALTH AGENCY	101.00	0	11,954	0	31.00
0			0	13,985,271		
N - POST ICU						
1.00	INTENSIVE CARE UNIT	31.00	781,143	93,337	0	1.00
0			781,143	93,337		
O - MME DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	7,197,999	9	1.00
0			0	7,197,999		
P - UTILITIES EXPENSE						
1.00	AMBULANCE SERVICES	95.00	0	6,423	0	1.00
0			0	6,423		
Q - NURSE FLOATS & SHIFT COORDINATORS						
1.00	NURSING ADMINISTRATION	13.00	353,625	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
0			353,625	0		

RECLASSIFICATIONS

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018

Worksheet A-6

Date/Time Prepared:
9/24/2018 11:56 am

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	R - RADIOLOGY MANAGEMENT					
1.00	ADMINISTRATIVE & GENERAL	5.00	597,231	37,375	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
	0		597,231	37,375		
	S - RADIOLOGY TECHS & PHLEBOTMIST					
1.00	CLINIC	90.00	58,328	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	0		58,328	0		
500.00	Grand Total: Decreases		5,113,889	46,604,768		500.00

RECLASSIFICATIONS

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
9/24/2018 11:56 am

Increases					Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
A - INTEREST EXPENSE									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	448,053	INTEREST EXPENSE	113.00	0	448,053	1.00
	0		0	448,053	0		0	448,053	
B - L&D AND NURSERY COST									
1.00	NURSERY	43.00	436,217	19,218	ADULTS & PEDIATRICS	30.00	1,282,988	56,523	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	846,771	37,305		0.00	0	0	2.00
	0		1,282,988	56,523			1,282,988	56,523	
C - OFFSITE BLDG									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	171,514	HOUSEKEEPING	9.00	0	9,347	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	748,814	OFFSITE BUILDINGS	194.02	0	1,439,376	2.00
3.00	OTHER CAP REL COSTS	3.00	0	18,236	CAP REL COSTS-BLDG & FIXT	1.00	0	6,066	3.00
4.00	OPERATION OF PLANT	7.00	0	500,812		0.00	0	0	4.00
5.00	OFFSITE BUILDINGS	194.02	0	6,066		0.00	0	0	5.00
6.00	OFFSITE BUILDINGS	194.02	0	9,347		0.00	0	0	6.00
	0		0	1,454,789			0	1,454,789	
D - PHYSICIAN REMUNERATION									
1.00	ADMINISTRATIVE & GENERAL	5.00	15,000	0	CLINIC	90.00	15,000	0	1.00
	0		15,000	0	0		15,000	0	
E - COLLECTIONS & BILLING EXP									
1.00	ADMINISTRATIVE & GENERAL	5.00	0	63,139	DIETARY	10.00	0	2,461	1.00
2.00		0.00	0	0	PHARMACY	15.00	0	8,454	2.00
3.00		0.00	0	0	AMBULANCE SERVICES	95.00	0	52,034	3.00
4.00		0.00	0	0	HOME INFUSION	98.00	0	3	4.00
5.00		0.00	0	0	HOME HEALTH AGENCY	101.00	0	187	5.00
	0		0	63,139	0		0	63,139	
F - CAFETERIA EXPENSE									
1.00	CAFETERIA	11.00	805,482	832,733	DIETARY	10.00	805,482	832,733	1.00
	0		805,482	832,733	0		805,482	832,733	
G - DRUG EXPENSE									
1.00	DRUGS CHARGED TO PATIENTS	73.00	1,220,092	21,735,030	NURSING	13.00	0	1,248	1.00
2.00		0.00	0	0	ADMINISTRATION		0	111	2.00
3.00		0.00	0	0	CENTRAL SERVICES & SUPPLY	14.00	0		
4.00		0.00	0	0	PHARMACY	15.00	1,220,092	8,466,844	3.00
5.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	11,855	4.00
6.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	3,127	5.00
7.00		0.00	0	0	RECOVERY ROOM	51.00	0	41,931	6.00
8.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	308,122	7.00
9.00		0.00	0	0	PAIN MANAGEMENT	53.01	0	2,079	8.00
10.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	6,413	9.00
11.00		0.00	0	0	ULTRASOUND	54.01	0	30	10.00
12.00		0.00	0	0	RADIOISOTOPE	56.00	0	252,934	11.00
13.00		0.00	0	0	CT SCAN	57.00	0	239	12.00
		0.00	0	0	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	252	13.00
14.00		0.00	0	0	CARDIAC	59.00	0	810	14.00
15.00		0.00	0	0	CATHETERIZATION		0		
16.00		0.00	0	0	LABORATORY	60.00	0	360	15.00
17.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	1,336	16.00
18.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	144	17.00
19.00		0.00	0	0	GI LAB	75.01	0	1,018	18.00
		0.00	0	0	HYPERBARIC OXYGEN THERAPY	76.98	0	53,156	19.00
20.00		0.00	0	0	CLINIC	90.00	0	12,555,922	20.00
21.00		0.00	0	0	EMERGENCY	91.00	0	21,769	21.00
22.00		0.00	0	0	AMBULANCE SERVICES	95.00	0	5,330	22.00
	0		1,220,092	21,735,030	0		1,220,092	21,735,030	
H - MARKETING & ADVERTISING									
1.00	ADMINISTRATIVE & GENERAL	5.00	0	16,207	NURSING	13.00	0	2,234	1.00
2.00		0.00	0	0	ADMINISTRATION		0		
3.00		0.00	0	0	PHARMACY	15.00	0	293	2.00
4.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	112	3.00
5.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	4,294	4.00
		0.00	0	0	HYPERBARIC OXYGEN THERAPY	76.98	0	1,918	5.00
6.00		0.00	0	0	CLINIC	90.00	0	350	6.00
7.00		0.00	0	0	HOME INFUSION	98.00	0	693	7.00
8.00		0.00	0	0	HOME HEALTH AGENCY	101.00	0	1,311	8.00

RECLASSIFICATIONS

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
9/24/2018 11:56 am

Increases					Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
9.00		0.00	0	0	PHYSICIANS' PRIVATE OFFICES	192.00	0	5,002	9.00
	0		0	16,207	0		0	16,207	
I - TELEPHONE EXPENSE									
1.00	ADMINISTRATIVE & GENERAL	5.00	0	130,316	OPERATION OF PLANT	7.00	0	995	1.00
2.00		0.00	0	0	NURSING ADMINISTRATION	13.00	0	157	2.00
3.00		0.00	0	0	PHARMACY	15.00	0	382	3.00
4.00		0.00	0	0	MEDICAL RECORDS & LIBRARY	16.00	0	403	4.00
5.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	7,499	5.00
6.00		0.00	0	0	OPERATING ROOM	50.00	0	7,889	6.00
7.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	6,001	7.00
8.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	497	8.00
9.00		0.00	0	0	LABORATORY	60.00	0	1,288	9.00
10.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	378	10.00
11.00		0.00	0	0	GI LAB	75.01	0	618	11.00
12.00		0.00	0	0	HYPERBARIC OXYGEN THERAPY	76.98	0	560	12.00
13.00		0.00	0	0	CLINIC	90.00	0	78,151	13.00
14.00		0.00	0	0	EMERGENCY	91.00	0	450	14.00
15.00		0.00	0	0	AMBULANCE SERVICES	95.00	0	8,267	15.00
16.00		0.00	0	0	HOME HEALTH AGENCY	101.00	0	7,085	16.00
17.00		0.00	0	0	PHYSICIANS' PRIVATE OFFICES	192.00	0	9,696	17.00
	0		0	130,316	0		0	130,316	
J - PROPERTY INSURANCE & TAXES									
1.00	CAP REL COSTS-BLDG & FIXT	1.00		336,048	ADMINISTRATIVE & GENERAL	5.00	0	8,922	1.00
2.00	OTHER CAP REL COSTS	3.00		194,075	OPERATION OF PLANT	7.00	0	336,048	2.00
3.00		0.00	0	0	OPERATION OF PLANT	7.00	0	134,584	3.00
4.00		0.00	0	0	AMBULANCE SERVICES	95.00	0	29,073	4.00
5.00		0.00	0	0	HOME INFUSION	98.00	0	1,278	5.00
6.00		0.00	0	0	HOME HEALTH AGENCY	101.00	0	16,222	6.00
7.00		0.00	0	0	COMMUNITY SERVICE	194.00	0	3,996	7.00
	0		0	530,123	0		0	530,123	
K - MALPRACTICE INSURANCE									
1.00	ADMINISTRATIVE & GENERAL	5.00	0	17,450	AMBULANCE SERVICES	95.00	0	17,200	1.00
2.00		0.00	0	0	HOME INFUSION	98.00	0	250	2.00
	0		0	17,450	0		0	17,450	
L - MEDICAL SUPPLIES									
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	13,985,271	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,013	1.00
2.00		0.00	0	0	CENTRAL SERVICES & SUPPLY	14.00	0	273,098	2.00
3.00		0.00	0	0	PHARMACY	15.00	0	100,207	3.00
4.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	462,573	4.00
5.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	112,272	5.00
6.00		0.00	0	0	OPERATING ROOM	50.00	0	5,567,722	6.00
7.00		0.00	0	0	RECOVERY ROOM	51.00	0	216,845	7.00
8.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	199,529	8.00
9.00		0.00	0	0	PAIN MANAGEMENT	53.01	0	54,558	9.00
10.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	150,693	10.00
11.00		0.00	0	0	ULTRASOUND	54.01	0	23,887	11.00
12.00		0.00	0	0	RADIOISOTOPE	56.00	0	643,503	12.00
13.00		0.00	0	0	CT SCAN	57.00	0	159,289	13.00
14.00		0.00	0	0	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	55,148	14.00
15.00		0.00	0	0	CARDIAC CATHETERIZATION	59.00	0	1,312,933	15.00
16.00		0.00	0	0	LABORATORY	60.00	0	1,666,211	16.00
17.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	168,801	17.00
18.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	4,424	18.00
19.00		0.00	0	0	OCCUPATIONAL THERAPY	67.00	0	2,378	19.00
20.00		0.00	0	0	SPEECH PATHOLOGY	68.00	0	2,150	20.00
21.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	50,675	21.00
22.00		0.00	0	0	ELECTROENCEPHALOGRAPH Y	70.00	0	40,465	22.00
23.00		0.00	0	0	RENAL DIALYSIS	74.00	0	742	23.00
24.00		0.00	0	0	GI LAB	75.01	0	961,545	24.00
25.00		0.00	0	0	DIABETIC EDUCATION	76.00	0	4,977	25.00
26.00		0.00	0	0	HYPERBARIC OXYGEN THERAPY	76.98	0	338,759	26.00

RECLASSIFICATIONS

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
9/24/2018 11:56 am

Increases					Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
27.00		0.00	0	0	CLINIC	90.00	0	905,599	27.00
28.00		0.00	0	0	EMERGENCY	91.00	0	443,933	28.00
29.00		0.00	0	0	AMBULANCE SERVICES	95.00	0	29,086	29.00
30.00		0.00	0	0	HOME INFUSION	98.00	0	20,302	30.00
31.00		0.00	0	0	HOME HEALTH AGENCY	101.00	0	11,954	31.00
				13,985,271				13,985,271	
N - POST ICU									
1.00	ADULTS & PEDIATRICS	30.00	781,143	93,337	INTENSIVE CARE UNIT	31.00	781,143	93,337	1.00
			781,143	93,337			781,143	93,337	
O - MME DEPRECIATION									
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	7,197,999	CAP REL COSTS-BLDG & FIXT	1.00	0	7,197,999	1.00
			0	7,197,999			0	7,197,999	
P - UTILITIES EXPENSE									
1.00	OPERATION OF PLANT	7.00	0	6,423	AMBULANCE SERVICES	95.00	0	6,423	1.00
			0	6,423			0	6,423	
Q - NURSE FLOATS & SHIFT COORDINATORS									
1.00	ADULTS & PEDIATRICS	30.00	272,543	0	NURSING ADMINISTRATION	13.00	353,625	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	46,443	0		0.00	0	0	2.00
3.00	NURSERY	43.00	11,778	0		0.00	0	0	3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	22,861	0		0.00	0	0	4.00
			353,625	0			353,625	0	
R - RADIOLOGY MANAGEMENT									
1.00	RADIOLOGY-DIAGNOSTIC	54.00	318,515	19,933	ADMINISTRATIVE & GENERAL	5.00	597,231	37,375	1.00
2.00	ULTRASOUND	54.01	68,306	4,275		0.00	0	0	2.00
3.00	RADIOISOTOPE	56.00	36,198	2,265		0.00	0	0	3.00
4.00	CT SCAN	57.00	111,902	7,003		0.00	0	0	4.00
5.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	62,310	3,899		0.00	0	0	5.00
			597,231	37,375			597,231	37,375	
S - RADIOLOGY TECHS & PHLEBOTMIST									
1.00	RADIOLOGY-DIAGNOSTIC	54.00	46,079	0	CLINIC	90.00	58,328	0	1.00
2.00	ULTRASOUND	54.01	151	0		0.00	0	0	2.00
3.00	LABORATORY	60.00	12,098	0		0.00	0	0	3.00
			58,328	0			58,328	0	
500.00	Grand Total: Increases		5,113,889	46,604,768	Grand Total: Decreases		5,113,889	46,604,768	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018Worksheet A-7
Part I
Date/Time Prepared:
9/24/2018 11:56 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	2,724,440	0	0	0	0	1.00	
2.00	Land Improvements	4,160,839	133,570	0	133,570	110,206	2.00	
3.00	Buildings and Fixtures	90,086,486	1,506,509	0	1,506,509	511,892	3.00	
4.00	Building Improvements	13,629,172	0	0	0	445,974	4.00	
5.00	Fixed Equipment	502,503	88,719	0	88,719	67,218	5.00	
6.00	Movable Equipment	81,585,521	5,970,646	0	5,970,646	3,680,295	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	192,688,961	7,699,444	0	7,699,444	4,815,585	8.00	
9.00	Reconciling Items	-1,447,534	-5,285,592	0	-5,285,592	0	9.00	
10.00	Total (line 8 minus line 9)	194,136,495	12,985,036	0	12,985,036	4,815,585	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	2,724,440	0					1.00
2.00	Land Improvements	4,184,203	0					
3.00	Buildings and Fixtures	91,081,103	0					
4.00	Building Improvements	13,183,198	0					4.00
5.00	Fixed Equipment	524,004	0					
6.00	Movable Equipment	83,875,872	0					
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	195,572,820	0					
9.00	Reconciling Items	-6,733,126	0					
10.00	Total (line 8 minus line 9)	202,305,946	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018Worksheet A-7
Part II
Date/Time Prepared:
9/24/2018 11:56 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	11,112,367	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	11,112,367	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	11,112,367				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	11,112,367				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018Worksheet A-7
Part III
Date/Time Prepared:
9/24/2018 11:56 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	111,172,944	0	111,172,944	0.568448	120,688	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	84,399,876	0	84,399,876	0.431552	91,623	2.00
3.00	Total (sum of lines 1-2)	195,572,820	0	195,572,820	1.000000	212,311	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	120,688	3,908,302	748,814	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	91,623	7,161,201	0	2.00
3.00	Total (sum of lines 1-2)	0	0	212,311	11,069,503	748,814	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	120,688	507,562	0	5,285,366	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	91,623	0	0	7,252,824	2.00
3.00	Total (sum of lines 1-2)	0	212,311	507,562	0	12,538,190	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018

Worksheet A-8

Date/Time Prepared:
9/24/2018 11:56 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00		B	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-448,053	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-165,029	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-42,225,063			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	0			0	12.00
13.00	Laundry and linen service	B	-6,682	LAUNDRY & LINEN SERVICE	8.00	0	13.00
14.00	Cafeteria-employees and guests	B	-804,067	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	B	-2,082,823	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-82,103	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-814	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** 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
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	DAYCARE RENT	B	-18,000	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018

Worksheet A-8

Date/Time Prepared:
9/24/2018 11:56 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.01	DIETARY CATERING REVENUE	B	-7,586	CAFETERIA	11.00	0	33.01
33.02	RENTAL INCOME	B	-7,704	OPERATION OF PLANT	7.00	0	33.02
33.03	MISC INCOME - PHARMACY	B	-4,000	PHARMACY	15.00	0	33.03
33.04	MISC INCOME - A&G	B	-228,831	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	MISC INCOME - RT	B	-2,972	RESPIRATORY THERAPY	65.00	0	33.05
33.06	MISC INCOME - AMBULANCE	B	-1,507	AMBULANCE SERVICES	95.00	0	33.06
33.07	MISC INCOME - A&P	B	-39	ADULTS & PEDIATRICS	30.00	0	33.07
33.08	HOME NURSING INCOME	B	0	HOME HEALTH AGENCY	101.00	0	33.08
33.09	CARDIAC REHAB PHASE III REVENUE	B	-13,570	ELECTROCARDIOLOGY	69.00	0	33.09
33.10	MISC INCOME - CAT SCAN	B	0	CT SCAN	57.00	0	33.10
33.11	BLOOD DRAW INCOME	B	-1,261	HOME INFUSION	98.00	0	33.11
33.12	HOUSEKEEPING REVENUE	B	-417	HOUSEKEEPING	9.00	0	33.12
33.13	PATIENT ACCOUNTING REVENUE	B	-52,309	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	DAYCARE REVENUE	B	-500,749	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	DAYCARE DISCOUNT EXPENSE ELIMINATION	A	-26,688	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.15
33.16	FORGIVENESS OF DEBT	A	11,401	ADMINISTRATIVE & GENERAL	5.00	0	33.16
35.00	LOBBYING EXPENSE	A	-44,910	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	PHYSICIAN RECRUITMENT SALARIES	A	-85,401	ADMINISTRATIVE & GENERAL	5.00	0	36.00
36.01	PHYSICIAN RECRUITMENT OTHER EXPENSES	A	-589,872	ADMINISTRATIVE & GENERAL	5.00	0	36.01
36.02	PHYSICIAN RECRUITMENT BENEFITS	A	-45,088	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36.02
36.03	PHYSICIAN RECRUITMENT	A	-268	CAP REL COSTS-MVBLE EQUIP	2.00	9	36.03
37.00	MARKETING SALARIES	A	-252,494	ADMINISTRATIVE & GENERAL	5.00	0	37.00
37.01	MARKETING OTHER EXPENSES	A	-617,218	ADMINISTRATIVE & GENERAL	5.00	0	37.01
37.02	MARKETING DEPRECIATION	A	-36,530	CAP REL COSTS-MVBLE EQUIP	2.00	9	37.02
37.03	MARKETING BENEFITS	A	-86,878	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37.03
38.00	CABLE TELEVISION	A	-43,204	ADMINISTRATIVE & GENERAL	5.00	0	38.00
38.01	CABLE TELEVISION	A	-2,891	CLINIC	90.00	0	38.01
39.00	CRNA SALARIES	A	-2,103,247	ANESTHESIOLOGY	53.00	0	39.00
39.01	CRNA LOCUM TENENS	A	-182,810	ANESTHESIOLOGY	53.00	0	39.01
39.02	CRNA MALPRACTICE INSURANCE	A	-29,948	ANESTHESIOLOGY	53.00	0	39.02
39.03	CRNA PHYSICIAN CME EXPENSE	A	-21,529	ANESTHESIOLOGY	53.00	0	39.03
39.04	CRNA FICA TAXES	A	-56,222	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.04
39.05	CRNA MEDICARE TAXES	A	-30,833	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.05
39.06	CRNA BENEFITS	A	-274,133	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.06
40.00	ALCOHOLIC BEVERAGE EXPENSE	A	-5,825	ADMINISTRATIVE & GENERAL	5.00	0	40.00
40.01	DEFINED BENEFIT PENSION FUNDING ADJ	A	621,399	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.01
41.00	PHYSICIAN BENEFITS	A	-3,547,841	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	41.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-54,104,609				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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018

Worksheet A-8-2

Date/Time Prepared:
9/24/2018 11:56 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	164,838	0	164,838	211,500	1,079	1.00
2.00	30.00	ADULTS & PEDIATRICS	2,827,356	2,827,356	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	50,293	50,293	0	0	0	3.00
4.00	53.01	PAIN MANAGEMENT	768,885	768,885	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	1,278,266	1,278,266	0	0	0	5.00
6.00	54.01	ULTRASOUND	532,201	532,201	0	0	0	6.00
7.00	56.00	RADIOISOTOPE	54,789	54,789	0	0	0	7.00
8.00	57.00	CT SCAN	1,723,862	1,723,862	0	0	0	8.00
9.00	58.00	MAGNETIC RESONANCE IMAGING (MRI)	580,805	580,805	0	0	0	9.00
10.00	60.00	LABORATORY	848,009	848,009	0	0	0	10.00
11.00	70.00	ELECTROENCEPHALOGRAPHY	1,300	1,300	0	0	0	11.00
12.00	76.98	HYPERBARIC OXYGEN THERAPY	495,546	495,546	0	0	0	12.00
13.00	90.00	CLINIC	28,248,758	28,248,758	0	0	0	13.00
14.00	91.00	EMERGENCY	4,759,871	4,759,871	0	0	0	14.00
200.00			42,334,779	42,169,941	164,838		1,079	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	109,716	5,486	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	14,787	0	119,015	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	50,293	3.00
4.00	53.01	PAIN MANAGEMENT	0	0	722	0	15,347	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	54.01	ULTRASOUND	0	0	0	0	0	6.00
7.00	56.00	RADIOISOTOPE	0	0	0	0	0	7.00
8.00	57.00	CT SCAN	0	0	0	0	0	8.00
9.00	58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	9.00
10.00	60.00	LABORATORY	0	0	1,414	0	20,227	10.00
11.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	11.00
12.00	76.98	HYPERBARIC OXYGEN THERAPY	0	0	0	0	11,269	12.00
13.00	90.00	CLINIC	0	0	228,937	0	963,582	13.00
14.00	91.00	EMERGENCY	0	0	0	0	0	14.00
200.00			109,716	5,486	245,860	0	1,179,733	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	109,716	55,122	55,122		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,827,356		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	50,293		3.00
4.00	53.01	PAIN MANAGEMENT	0	0	0	768,885		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,278,266		5.00
6.00	54.01	ULTRASOUND	0	0	0	532,201		6.00
7.00	56.00	RADIOISOTOPE	0	0	0	54,789		7.00
8.00	57.00	CT SCAN	0	0	0	1,723,862		8.00
9.00	58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	580,805		9.00
10.00	60.00	LABORATORY	0	0	0	848,009		10.00
11.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	1,300		11.00
12.00	76.98	HYPERBARIC OXYGEN THERAPY	0	0	0	495,546		12.00
13.00	90.00	CLINIC	0	0	0	28,248,758		13.00
14.00	91.00	EMERGENCY	0	0	0	4,759,871		14.00
200.00			0	109,716	55,122	42,225,063		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018Worksheet B
Part I
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Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	5,285,366	5,285,366			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	7,252,824	7,252,824			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	29,697,246	15,456	7,748	29,720,450	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	22,013,931	901,835	1,670,766	5,704,826	5.00
7.00	00700	OPERATION OF PLANT	3,862,476	170,317	59,402	538,712	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	408,121	65,475	34,600	121,862	8.00
9.00	00900	HOUSEKEEPING	2,217,042	6,808	21,478	501,336	9.00
10.00	01000	DIETARY	356,492	15,299	14,672	82,359	10.00
11.00	01100	CAFETERIA	825,748	69,799	66,975	375,877	11.00
13.00	01300	NURSING ADMINISTRATION	790,416	2,429	61,607	267,101	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	687,146	9,614	23,909	263,940	14.00
15.00	01500	PHARMACY	326,510	28,704	172,500	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,777,617	49,228	30,469	926,428	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,312,582	432,568	341,337	3,712,404	30.00
31.00	03100	INTENSIVE CARE UNIT	1,745,743	93,526	118,557	712,371	31.00
43.00	04300	NURSERY	467,213	79,303	48,190	209,056	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,039,295	223,998	682,449	785,926	50.00
51.00	05100	RECOVERY ROOM	980,127	122,432	74,675	437,587	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	906,937	95,761	93,459	405,813	52.00
53.00	05300	ANESTHESIOLOGY	39,749	5,888	13,592	0	53.00
53.01	05301	PAIN MANAGEMENT	224,161	27,600	15,269	98,555	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,081,464	175,340	687,427	726,583	54.00
54.01	05401	ULTRASOUND	689,793	26,974	75,254	206,494	54.01
56.00	05600	RADIOISOTOPE	395,650	63,405	146,162	130,428	56.00
57.00	05700	CT SCAN	872,364	17,581	156,299	302,461	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	567,802	36,349	40,515	190,344	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,080,073	72,311	580,918	313,884	59.00
60.00	06000	LABORATORY	4,698,577	103,765	251,897	1,105,514	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	916,071	47,968	125,954	402,419	65.00
66.00	06600	PHYSICAL THERAPY	369,309	8,556	3,303	168,935	66.00
67.00	06700	OCCUPATIONAL THERAPY	82,435	3,689	0	36,819	67.00
68.00	06800	SPEECH PATHOLOGY	188,562	1,104	0	83,424	68.00
69.00	06900	ELECTROCARDIOLOGY	916,914	37,425	75,539	393,168	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	256,169	12,061	17,092	117,179	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,985,271	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,872,299	0	0	569,355	73.00
74.00	07400	RENAL DIALYSIS	197,450	1,840	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01	07501	GI LAB	1,153,967	32,374	265,254	464,299	75.01
76.00	03950	DIABETIC EDUCATION	274,929	14,306	2,198	104,192	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	702,616	37,269	17,148	148,309	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	9,226,290	1,502,117	363,010	3,961,814	90.00
91.00	09100	EMERGENCY	3,490,176	191,909	748,996	1,570,810	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,558,804	29,053	65,654	658,077	95.00
98.00	09850	HOME INFUSION	124,205	1,932	0	29,085	98.00
101.00	10100	HOME HEALTH AGENCY	1,220,143	21,344	25,091	481,701	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	157,138,075	4,854,712	7,199,365	27,309,447	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	63,316	11,656	1,096	10,655	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,444,949	316,300	33,256	1,618,303	192.00
194.00	07950	COMMUNITY SERVICE	365,645	15,713	0	122,759	194.00
194.01	07951	OFFSITE FREESTANDING PT/OT	1,502,044	86,985	19,107	659,286	194.01
194.02	07952	OFFSITE BUILDINGS	141,108	0	0	0	194.02
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	163,655,137	5,285,366	7,252,824	29,720,450	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018Worksheet B
Part I
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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	30,291,358					5.00
7.00	00700	OPERATION OF PLANT	1,051,832	5,682,739				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	143,107	88,638	861,803			8.00
9.00	00900	HOUSEKEEPING	623,858	9,216	70,574	3,450,312		9.00
10.00	01000	DIETARY	106,485	20,712	2,420	12,796	611,235	10.00
11.00	01100	CAFETERIA	303,995	94,491	11,048	58,376	0	11.00
13.00	01300	NURSING ADMINISTRATION	254,742	3,288	0	2,031	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	223,637	13,015	0	8,040	0	14.00
15.00	01500	PHARMACY	119,861	38,858	0	24,006	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	859,413	66,643	0	41,172	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,907,051	585,592	314,271	361,775	571,632	30.00
31.00	03100	INTENSIVE CARE UNIT	606,490	126,611	32,755	78,220	39,603	31.00
43.00	04300	NURSERY	182,561	107,357	15,681	66,324	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	847,585	303,239	94,128	187,339	0	50.00
51.00	05100	RECOVERY ROOM	366,779	165,743	0	102,395	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	341,147	129,637	30,429	80,089	0	52.00
53.00	05300	ANESTHESIOLOGY	13,453	7,971	0	4,924	0	53.00
53.01	05301	PAIN MANAGEMENT	83,036	37,363	0	23,083	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	833,763	237,368	37,976	146,645	0	54.00
54.01	05401	ULTRASOUND	226,796	36,516	0	22,560	0	54.01
56.00	05600	RADIOISOTOPE	167,089	85,835	0	53,029	0	56.00
57.00	05700	CT SCAN	306,335	23,800	0	14,704	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	189,658	49,207	0	30,400	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	464,983	97,891	0	60,477	0	59.00
60.00	06000	LABORATORY	1,399,083	140,473	0	86,783	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	338,976	64,937	0	40,118	0	65.00
66.00	06600	PHYSICAL THERAPY	124,947	11,583	0	7,156	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	27,924	4,994	0	3,085	0	67.00
68.00	06800	SPEECH PATHOLOGY	62,028	1,495	0	923	0	68.00
69.00	06900	ELECTROCARDIOLOGY	323,221	50,664	0	31,300	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	91,421	16,328	0	10,087	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,176,517	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,870,149	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	45,265	2,491	0	1,539	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	GI LAB	435,163	43,827	33,409	27,076	0	75.01
76.00	03950	DIABETIC EDUCATION	89,859	19,367	0	11,965	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	205,633	50,453	4,304	31,169	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,419,086	2,033,497	29,498	1,256,283	0	90.00
91.00	09100	EMERGENCY	1,363,228	259,798	139,140	160,502	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	525,038	39,331	19,869	24,298	0	95.00
98.00	09850	HOME INFUSION	35,256	2,615	0	1,616	0	98.00
101.00	10100	HOME HEALTH AGENCY	397,092	28,894	0	17,851	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,153,542	5,099,738	835,502	3,090,136	611,235	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19,698	15,780	0	9,749	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,456,560	428,193	4,822	264,536	0	192.00
194.00	07950	COMMUNITY SERVICE	114,502	21,272	0	13,142	0	194.00
194.01	07951	OFFSITE FREESTANDING PT/OT	515,006	117,756	21,479	72,749	0	194.01
194.02	07952	OFFSITE BUILDINGS	32,050	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	30,291,358	5,682,739	861,803	3,450,312	611,235	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018Worksheet B
Part I
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	1,806,309					11.00
13.00	01300	NURSING ADMINISTRATION	6,111	1,387,725				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	23,327	0	1,252,628			14.00
15.00	01500	PHARMACY	0	0	177	710,616		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	81,358	0	2	0	4,832,330	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	287,339	341,643	4,237	0	259,819	30.00
31.00	03100	INTENSIVE CARE UNIT	46,925	58,218	3,565	0	42,520	31.00
43.00	04300	NURSERY	11,898	14,764	0	0	22,966	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	48,998	60,780	3,915	0	331,188	50.00
51.00	05100	RECOVERY ROOM	29,565	36,673	549	0	51,918	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	23,093	28,658	0	0	44,581	52.00
53.00	05300	ANESTHESIOLOGY	12,150	0	388	0	125,302	53.00
53.01	05301	PAIN MANAGEMENT	8,545	8,367	4	0	39,007	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	53,577	0	314	0	215,119	54.00
54.01	05401	ULTRASOUND	11,483	0	0	0	105,815	54.01
56.00	05600	RADIOISOTOPE	6,093	0	32	0	95,103	56.00
57.00	05700	CT SCAN	18,821	0	0	0	436,135	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	10,474	0	0	0	137,481	58.00
59.00	05900	CARDIAC CATHETERIZATION	18,875	23,411	571	0	144,560	59.00
60.00	06000	LABORATORY	98,610	0	1,505	0	731,238	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	26,464	0	498	0	55,795	65.00
66.00	06600	PHYSICAL THERAPY	10,816	0	0	0	10,416	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,001	0	0	0	1,855	67.00
68.00	06800	SPEECH PATHOLOGY	4,074	0	0	0	3,425	68.00
69.00	06900	ELECTROCARDIOLOGY	29,673	36,813	470	0	166,514	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	9,176	0	0	0	38,310	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,178,144	0	153,526	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	30,935	0	0	710,616	459,557	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	2,962	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	GI LAB	33,441	41,497	1,228	0	183,730	75.01
76.00	03950	DIABETIC EDUCATION	8,455	0	842	0	3,238	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	13,196	0	0	0	96,490	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	512,088	449,617	4,086	0	310,592	90.00
91.00	09100	EMERGENCY	113,735	141,116	722	0	385,913	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	55,380	0	110	0	41,818	95.00
98.00	09850	HOME INFUSION	2,668	3,304	0	0	2,899	98.00
101.00	10100	HOME HEALTH AGENCY	25,851	32,084	0	0	9,670	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,675,195	1,276,945	1,201,359	710,616	4,709,462	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,767	0	130	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	82,133	95,162	47,350	0	61,793	192.00
194.00	07950	COMMUNITY SERVICE	7,211	15,618	134	0	0	194.00
194.01	07951	OFFSITE FREESTANDING PT/OT	40,003	0	3,655	0	61,075	194.01
194.02	07952	OFFSITE BUILDINGS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,806,309	1,387,725	1,252,628	710,616	4,832,330	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018Worksheet B
Part I
Date/Time Prepared:
9/24/2018 11:56 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
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
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,432,250	-692,803	17,739,447	30.00
31.00	03100	INTENSIVE CARE UNIT	3,705,104	-147,097	3,558,007	31.00
43.00	04300	NURSERY	1,225,313	0	1,225,313	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,608,840	0	5,608,840	50.00
51.00	05100	RECOVERY ROOM	2,368,443	190,417	2,558,860	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,179,604	0	2,179,604	52.00
53.00	05300	ANESTHESIOLOGY	223,417	0	223,417	53.00
53.01	05301	PAIN MANAGEMENT	564,990	0	564,990	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,195,576	0	5,195,576	54.00
54.01	05401	ULTRASOUND	1,401,685	0	1,401,685	54.01
56.00	05600	RADIOISOTOPE	1,142,826	0	1,142,826	56.00
57.00	05700	CT SCAN	2,148,500	0	2,148,500	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,252,230	0	1,252,230	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,857,954	0	2,857,954	59.00
60.00	06000	LABORATORY	8,617,445	0	8,617,445	60.00
64.00	06400	INTRAVENOUS THERAPY	0	649,483	649,483	64.00
65.00	06500	RESPIRATORY THERAPY	2,019,200	0	2,019,200	65.00
66.00	06600	PHYSICAL THERAPY	715,021	0	715,021	66.00
67.00	06700	OCCUPATIONAL THERAPY	162,802	0	162,802	67.00
68.00	06800	SPEECH PATHOLOGY	345,035	0	345,035	68.00
69.00	06900	ELECTROCARDIOLOGY	2,061,701	0	2,061,701	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	567,823	0	567,823	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,493,458	0	18,493,458	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,512,911	0	27,512,911	73.00
74.00	07400	RENAL DIALYSIS	251,547	0	251,547	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	75.00
75.01	07501	GI LAB	2,715,265	0	2,715,265	75.01
76.00	03950	DIABETIC EDUCATION	529,351	0	529,351	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,306,587	0	1,306,587	76.98
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	23,067,978	0	23,067,978	90.00
91.00	09100	EMERGENCY	8,566,045	0	8,566,045	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,017,432	0	3,017,432	95.00
98.00	09850	HOME INFUSION	203,580	0	203,580	98.00
101.00	10100	HOME HEALTH AGENCY	2,259,721	0	2,259,721	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	150,719,634	0	150,719,634	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	133,847	0	133,847	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,853,357	0	8,853,357	192.00
194.00	07950	COMMUNITY SERVICE	675,996	0	675,996	194.00
194.01	07951	OFFSITE FREESTANDING PT/OT	3,099,145	0	3,099,145	194.01
194.02	07952	OFFSITE BUILDINGS	173,158	0	173,158	194.02
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	163,655,137	0	163,655,137	202.00

COST ALLOCATION STATISTICS

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018

Worksheet Non-CMS W

Date/Time Prepared:
9/24/2018 11:56 am

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
1.00	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-5	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	8	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	10	MEALS SERVED	10.00
11.00	CAFETERIA	18	FTES	11.00
13.00	NURSING ADMINISTRATION	13	DIRECT NURS. HRS.	13.00
14.00	CENTRAL SERVICES & SUPPLY	14	COSTED REQUIS.	14.00
15.00	PHARMACY	15	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	16	GROSS CHARGES	16.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	15,456	7,748	23,204	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	73,424	901,835	1,670,766	2,646,025	5.00
7.00	00700	OPERATION OF PLANT	5,256	170,317	59,402	234,975	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	65,475	34,600	100,075	8.00
9.00	00900	HOUSEKEEPING	0	6,808	21,478	28,286	9.00
10.00	01000	DIETARY	0	15,299	14,672	29,971	10.00
11.00	01100	CAFETERIA	0	69,799	66,975	136,774	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,429	61,607	64,036	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	9,614	23,909	33,523	14.00
15.00	01500	PHARMACY	0	28,704	172,500	201,204	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	49,228	30,469	79,697	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	432,568	341,337	773,905	30.00
31.00	03100	INTENSIVE CARE UNIT	0	93,526	118,557	212,083	31.00
43.00	04300	NURSERY	0	79,303	48,190	127,493	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	52,620	223,998	682,449	959,067	50.00
51.00	05100	RECOVERY ROOM	0	122,432	74,675	197,107	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	95,761	93,459	189,220	52.00
53.00	05300	ANESTHESIOLOGY	0	5,888	13,592	19,480	53.00
53.01	05301	PAIN MANAGEMENT	0	27,600	15,269	42,869	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	175,340	687,427	862,767	54.00
54.01	05401	ULTRASOUND	0	26,974	75,254	102,228	54.01
56.00	05600	RADIOISOTOPE	0	63,405	146,162	209,567	56.00
57.00	05700	CT SCAN	0	17,581	156,299	173,880	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	36,349	40,515	76,864	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	72,311	580,918	653,229	59.00
60.00	06000	LABORATORY	0	103,765	251,897	355,662	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	47,968	125,954	173,922	65.00
66.00	06600	PHYSICAL THERAPY	0	8,556	3,303	11,859	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,689	0	3,689	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,104	0	1,104	68.00
69.00	06900	ELECTROCARDIOLOGY	0	37,425	75,539	112,964	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,334	12,061	17,092	30,487	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	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	1,840	0	1,840	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01	07501	GI LAB	0	32,374	265,254	297,628	75.01
76.00	03950	DIABETIC EDUCATION	0	14,306	2,198	16,504	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	37,269	17,148	54,417	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	1,502,117	363,010	1,865,127	90.00
91.00	09100	EMERGENCY	0	191,909	748,996	940,905	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	29,053	65,654	94,707	95.00
98.00	09850	HOME INFUSION	0	1,932	0	1,932	98.00
101.00	10100	HOME HEALTH AGENCY	0	21,344	25,091	46,435	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	132,634	4,854,712	7,199,365	12,186,711	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,656	1,096	12,752	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	316,300	33,256	349,556	192.00
194.00	07950	COMMUNITY SERVICE	0	15,713	0	15,713	194.00
194.01	07951	OFFSITE FREESTANDING PT/OT	0	86,985	19,107	106,092	194.01
194.02	07952	OFFSITE BUILDINGS	72,917	0	0	72,917	194.02
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	205,551	5,285,366	7,252,824	12,743,741	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,650,497					5.00
7.00	00700	OPERATION OF PLANT	92,035	327,430				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,522	5,107	117,799			8.00
9.00	00900	HOUSEKEEPING	54,587	531	9,647	93,442		9.00
10.00	01000	DIETARY	9,317	1,193	331	347	41,223	10.00
11.00	01100	CAFETERIA	26,599	5,444	1,510	1,581	0	11.00
13.00	01300	NURSING ADMINISTRATION	22,290	189	0	55	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	19,568	750	0	218	0	14.00
15.00	01500	PHARMACY	10,488	2,239	0	650	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	75,198	3,840	0	1,115	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	254,365	33,741	42,958	9,798	38,552	30.00
31.00	03100	INTENSIVE CARE UNIT	53,067	7,295	4,477	2,118	2,671	31.00
43.00	04300	NURSERY	15,974	6,186	2,143	1,796	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	74,163	17,472	12,866	5,074	0	50.00
51.00	05100	RECOVERY ROOM	32,093	9,550	0	2,773	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,850	7,469	4,159	2,169	0	52.00
53.00	05300	ANESTHESIOLOGY	1,177	459	0	133	0	53.00
53.01	05301	PAIN MANAGEMENT	7,266	2,153	0	625	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	72,954	13,677	5,191	3,971	0	54.00
54.01	05401	ULTRASOUND	19,844	2,104	0	611	0	54.01
56.00	05600	RADIOISOTOPE	14,620	4,946	0	1,436	0	56.00
57.00	05700	CT SCAN	26,804	1,371	0	398	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	16,595	2,835	0	823	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	40,686	5,640	0	1,638	0	59.00
60.00	06000	LABORATORY	122,419	8,094	0	2,350	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	29,660	3,742	0	1,086	0	65.00
66.00	06600	PHYSICAL THERAPY	10,933	667	0	194	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,443	288	0	84	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,427	86	0	25	0	68.00
69.00	06900	ELECTROCARDIOLOGY	28,282	2,919	0	848	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,999	941	0	273	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	277,943	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	426,158	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	3,961	144	0	42	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	GI LAB	38,076	2,525	4,567	733	0	75.01
76.00	03950	DIABETIC EDUCATION	7,863	1,116	0	324	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	17,993	2,907	588	844	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	299,168	117,167	4,032	34,024	0	90.00
91.00	09100	EMERGENCY	119,282	14,969	19,019	4,347	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	45,940	2,266	2,716	658	0	95.00
98.00	09850	HOME INFUSION	3,085	151	0	44	0	98.00
101.00	10100	HOME HEALTH AGENCY	34,745	1,665	0	483	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,463,439	293,838	114,204	83,688	41,223	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,724	909	0	264	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	127,448	24,672	659	7,164	0	192.00
194.00	07950	COMMUNITY SERVICE	10,019	1,226	0	356	0	194.00
194.01	07951	OFFSITE FREESTANDING PT/OT	45,063	6,785	2,936	1,970	0	194.01
194.02	07952	OFFSITE BUILDINGS	2,804	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,650,497	327,430	117,799	93,442	41,223	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	172,201					11.00
13.00	01300	NURSING ADMINISTRATION	583	87,361				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,224	0	56,489			14.00
15.00	01500	PHARMACY	0	0	8	214,589		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,756	0	0	0	168,329	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	27,393	21,507	191	0	9,063	30.00
31.00	03100	INTENSIVE CARE UNIT	4,474	3,665	161	0	1,483	31.00
43.00	04300	NURSERY	1,134	929	0	0	801	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,671	3,826	177	0	11,553	50.00
51.00	05100	RECOVERY ROOM	2,819	2,309	25	0	1,811	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,202	1,804	0	0	1,555	52.00
53.00	05300	ANESTHESIOLOGY	1,158	0	17	0	4,371	53.00
53.01	05301	PAIN MANAGEMENT	815	527	0	0	1,361	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,108	0	14	0	7,504	54.00
54.01	05401	ULTRASOUND	1,095	0	0	0	3,691	54.01
56.00	05600	RADIOISOTOPE	581	0	1	0	3,317	56.00
57.00	05700	CT SCAN	1,794	0	0	0	15,213	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	999	0	0	0	4,796	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,799	1,474	26	0	5,043	59.00
60.00	06000	LABORATORY	9,401	0	68	0	25,277	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,523	0	22	0	1,946	65.00
66.00	06600	PHYSICAL THERAPY	1,031	0	0	0	363	66.00
67.00	06700	OCCUPATIONAL THERAPY	191	0	0	0	65	67.00
68.00	06800	SPEECH PATHOLOGY	388	0	0	0	119	68.00
69.00	06900	ELECTROCARDIOLOGY	2,829	2,317	21	0	5,808	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	875	0	0	0	1,336	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	53,131	0	5,355	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,949	0	0	214,589	16,030	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	103	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	GI LAB	3,188	2,612	55	0	6,409	75.01
76.00	03950	DIABETIC EDUCATION	806	0	38	0	113	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,258	0	0	0	3,366	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	48,817	28,305	184	0	10,834	90.00
91.00	09100	EMERGENCY	10,843	8,884	33	0	13,461	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	5,280	0	5	0	1,459	95.00
98.00	09850	HOME INFUSION	254	208	0	0	101	98.00
101.00	10100	HOME HEALTH AGENCY	2,464	2,020	0	0	337	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	159,702	80,387	54,177	214,589	164,044	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	168	0	6	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,830	5,991	2,135	0	2,155	192.00
194.00	07950	COMMUNITY SERVICE	687	983	6	0	0	194.00
194.01	07951	OFFSITE FREESTANDING PT/OT	3,814	0	165	0	2,130	194.01
194.02	07952	OFFSITE BUILDINGS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	172,201	87,361	56,489	214,589	168,329	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018Worksheet B
Part II
Date/Time Prepared:
9/24/2018 11:56 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
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
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,214,369	0	1,214,369	30.00
31.00	03100	INTENSIVE CARE UNIT	292,050	0	292,050	31.00
43.00	04300	NURSERY	156,619	0	156,619	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,089,482	0	1,089,482	50.00
51.00	05100	RECOVERY ROOM	248,828	0	248,828	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	238,745	0	238,745	52.00
53.00	05300	ANESTHESIOLOGY	26,795	0	26,795	53.00
53.01	05301	PAIN MANAGEMENT	55,693	0	55,693	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	971,753	0	971,753	54.00
54.01	05401	ULTRASOUND	129,734	0	129,734	54.01
56.00	05600	RADIOISOTOPE	234,570	0	234,570	56.00
57.00	05700	CT SCAN	219,696	0	219,696	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	103,060	0	103,060	58.00
59.00	05900	CARDIAC CATHETERIZATION	709,780	0	709,780	59.00
60.00	06000	LABORATORY	524,133	0	524,133	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	213,215	0	213,215	65.00
66.00	06600	PHYSICAL THERAPY	25,179	0	25,179	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,789	0	6,789	67.00
68.00	06800	SPEECH PATHOLOGY	7,214	0	7,214	68.00
69.00	06900	ELECTROCARDIOLOGY	156,295	0	156,295	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	42,002	0	42,002	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	336,429	0	336,429	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	660,170	0	660,170	73.00
74.00	07400	RENAL DIALYSIS	6,090	0	6,090	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	75.00
75.01	07501	GI LAB	356,155	0	356,155	75.01
76.00	03950	DIABETIC EDUCATION	26,845	0	26,845	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	81,489	0	81,489	76.98
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,410,748	0	2,410,748	90.00
91.00	09100	EMERGENCY	1,132,968	0	1,132,968	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	153,544	0	153,544	95.00
98.00	09850	HOME INFUSION	5,798	0	5,798	98.00
101.00	10100	HOME HEALTH AGENCY	88,525	0	88,525	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,924,762	0	11,924,762	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,831	0	15,831	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	528,872	0	528,872	192.00
194.00	07950	COMMUNITY SERVICE	29,086	0	29,086	194.00
194.01	07951	OFFSITE FREESTANDING PT/OT	169,469	0	169,469	194.01
194.02	07952	OFFSITE BUILDINGS	75,721	0	75,721	194.02
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	12,743,741	0	12,743,741	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018

Worksheet B-1

Date/Time Prepared:
9/24/2018 11:56 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	574,505				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		7,161,201			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,680	7,650	63,689,115		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	98,027	1,649,658	12,225,113	-30,291,358	5.00
7.00	00700	OPERATION OF PLANT	18,513	58,652	1,154,427	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,117	34,163	261,142	0	8.00
9.00	00900	HOUSEKEEPING	740	21,207	1,074,333	0	9.00
10.00	01000	DIETARY	1,663	14,487	176,491	0	10.00
11.00	01100	CAFETERIA	7,587	66,129	805,482	0	11.00
13.00	01300	NURSING ADMINISTRATION	264	60,829	572,381	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,045	23,607	565,607	0	14.00
15.00	01500	PHARMACY	3,120	170,321	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,351	30,084	1,985,279	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	47,019	337,025	7,955,453	0	30.00
31.00	03100	INTENSIVE CARE UNIT	10,166	117,059	1,526,568	0	31.00
43.00	04300	NURSERY	8,620	47,581	447,995	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	24,348	673,828	1,684,190	0	50.00
51.00	05100	RECOVERY ROOM	13,308	73,732	937,722	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,409	92,278	869,632	0	52.00
53.00	05300	ANESTHESIOLOGY	640	13,420	0	0	53.00
53.01	05301	PAIN MANAGEMENT	3,000	15,076	211,197	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,059	678,743	1,557,022	0	54.00
54.01	05401	ULTRASOUND	2,932	74,303	442,503	0	54.01
56.00	05600	RADIOISOTOPE	6,892	144,316	279,500	0	56.00
57.00	05700	CT SCAN	1,911	154,325	648,156	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,951	40,003	407,896	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,860	573,580	672,633	0	59.00
60.00	06000	LABORATORY	11,279	248,715	2,369,048	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	5,214	124,363	862,360	0	65.00
66.00	06600	PHYSICAL THERAPY	930	3,261	362,017	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	401	0	78,900	0	67.00
68.00	06800	SPEECH PATHOLOGY	120	0	178,772	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,068	74,585	842,534	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,311	16,876	251,107	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,220,092	0	73.00
74.00	07400	RENAL DIALYSIS	200	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01	07501	GI LAB	3,519	261,903	994,964	0	75.01
76.00	03950	DIABETIC EDUCATION	1,555	2,170	223,277	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	4,051	16,931	317,817	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	163,276	358,424	8,489,923	0	90.00
91.00	09100	EMERGENCY	20,860	739,534	3,366,148	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	3,158	64,825	1,410,218	0	95.00
98.00	09850	HOME INFUSION	210	0	62,327	0	98.00
101.00	10100	HOME HEALTH AGENCY	2,320	24,774	1,032,256	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	527,694	7,108,417	58,522,482	-30,291,358	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,267	1,082	22,833	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	34,381	32,836	3,467,924	0	192.00
194.00	07950	COMMUNITY SERVICE	1,708	0	263,066	0	194.00
194.01	07951	OFFSITE FREESTANDING PT/OT	9,455	18,866	1,412,810	0	194.01
194.02	07952	OFFSITE BUILDINGS	0	0	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,285,366	7,252,824	29,720,450	30,291,358	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.199861	1.012794	0.466649	0.227133	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018

Worksheet B-1

Date/Time Prepared:
9/24/2018 11:56 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
204.00		Cost to be allocated (per Wkst. B, Part II)			23,204		2,650,497	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000364		0.019874	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: 14-0043

Period:
From 05/01/2017
To 04/30/2018

Worksheet B-1

Date/Time Prepared:
9/24/2018 11:56 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	456,285				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,117	930,147			8.00
9.00	00900	HOUSEKEEPING	740	76,171	448,428		9.00
10.00	01000	DIETARY	1,663	2,612	1,663	47,058	10.00
11.00	01100	CAFETERIA	7,587	11,924	7,587	0	11.00
13.00	01300	NURSING ADMINISTRATION	264	0	264	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,045	0	1,045	0	14.00
15.00	01500	PHARMACY	3,120	0	3,120	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,351	0	5,351	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	47,019	339,193	47,019	44,009	30.00
31.00	03100	INTENSIVE CARE UNIT	10,166	35,353	10,166	3,049	31.00
43.00	04300	NURSERY	8,620	16,925	8,620	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	24,348	101,593	24,348	0	50.00
51.00	05100	RECOVERY ROOM	13,308	0	13,308	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,409	32,842	10,409	0	52.00
53.00	05300	ANESTHESIOLOGY	640	0	640	0	53.00
53.01	05301	PAIN MANAGEMENT	3,000	0	3,000	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,059	40,988	19,059	0	54.00
54.01	05401	ULTRASOUND	2,932	0	2,932	0	54.01
56.00	05600	RADIOISOTOPE	6,892	0	6,892	0	56.00
57.00	05700	CT SCAN	1,911	0	1,911	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,951	0	3,951	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,860	0	7,860	0	59.00
60.00	06000	LABORATORY	11,279	0	11,279	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	5,214	0	5,214	0	65.00
66.00	06600	PHYSICAL THERAPY	930	0	930	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	401	0	401	0	67.00
68.00	06800	SPEECH PATHOLOGY	120	0	120	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,068	0	4,068	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,311	0	1,311	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	200	0	200	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01	07501	GI LAB	3,519	36,059	3,519	0	75.01
76.00	03950	DIABETIC EDUCATION	1,555	0	1,555	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	4,051	4,645	4,051	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	163,276	31,837	163,276	0	90.00
91.00	09100	EMERGENCY	20,860	150,174	20,860	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	3,158	21,445	3,158	0	95.00
98.00	09850	HOME INFUSION	210	0	210	0	98.00
101.00	10100	HOME HEALTH AGENCY	2,320	0	2,320	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	409,474	901,761	401,617	47,058	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,267	0	1,267	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	34,381	5,204	34,381	0	192.00
194.00	07950	COMMUNITY SERVICE	1,708	0	1,708	0	194.00
194.01	07951	OFFSITE FREESTANDING PT/OT	9,455	23,182	9,455	0	194.01
194.02	07952	OFFSITE BUILDINGS	0	0	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,682,739	861,803	3,450,312	611,235	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.454363	0.926523	7.694239	12.988971	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	327,430	117,799	93,442	41,223	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.717600	0.126646	0.208377	0.876004	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018

Worksheet B-1

Date/Time Prepared:
9/24/2018 11:56 am

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			7.00	8.00	9.00	10.00	11.00	
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: 14-0043

Period:
From 05/01/2017
To 04/30/2018

Worksheet B-1

Date/Time Prepared:
9/24/2018 11:56 am

Cost Center Description			NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
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	1,290,547				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14,869,455			14.00
15.00	01500	PHARMACY	0	2,105	21,735,030		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	21	0	674,246,859	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	317,719	50,298	0	36,252,112	30.00
31.00	03100	INTENSIVE CARE UNIT	54,141	42,317	0	5,932,760	31.00
43.00	04300	NURSERY	13,730	0	0	3,204,402	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	56,524	46,471	0	46,210,133	50.00
51.00	05100	RECOVERY ROOM	34,105	6,514	0	7,244,018	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	26,651	0	0	6,220,298	52.00
53.00	05300	ANESTHESIOLOGY	0	4,606	0	17,483,230	53.00
53.01	05301	PAIN MANAGEMENT	7,781	48	0	5,442,630	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,727	0	30,015,146	54.00
54.01	05401	ULTRASOUND	0	0	0	14,764,218	54.01
56.00	05600	RADIOISOTOPE	0	385	0	13,269,549	56.00
57.00	05700	CT SCAN	0	0	0	60,853,272	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	19,182,544	58.00
59.00	05900	CARDIAC CATHETERIZATION	21,772	6,780	0	20,170,161	59.00
60.00	06000	LABORATORY	0	17,862	0	102,028,123	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	5,914	0	7,784,983	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,453,288	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	258,883	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	477,896	68.00
69.00	06900	ELECTROCARDIOLOGY	34,235	5,578	0	23,233,398	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	5,345,364	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	13,985,271	0	21,421,177	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	21,735,030	64,121,304	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	413,296	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01	07501	GI LAB	38,591	14,574	0	25,635,525	75.01
76.00	03950	DIABETIC EDUCATION	0	10,000	0	451,756	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	13,463,105	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	418,132	48,509	0	43,336,406	90.00
91.00	09100	EMERGENCY	131,234	8,570	0	53,845,855	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	1,304	0	5,834,810	95.00
98.00	09850	HOME INFUSION	3,073	0	0	404,441	98.00
101.00	10100	HOME HEALTH AGENCY	29,837	0	0	1,349,262	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,187,525	14,260,854	21,735,030	657,103,345	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,544	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	88,498	562,074	0	8,621,887	192.00
194.00	07950	COMMUNITY SERVICE	14,524	1,596	0	0	194.00
194.01	07951	OFFSITE FREESTANDING PT/OT	0	43,387	0	8,521,627	194.01
194.02	07952	OFFSITE BUILDINGS	0	0	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,387,725	1,252,628	710,616	4,832,330	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.075300	0.084242	0.032695	0.007167	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	87,361	56,489	214,589	168,329	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018

Worksheet B-1

Date/Time Prepared:
9/24/2018 11:56 am

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
		13.00	14.00	15.00	16.00		
205.00	Unit cost multiplier (Wkst. B, Part II)	0.067693	0.003799	0.009873	0.000250		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

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018

Worksheet B-2

Date/Time Prepared:
9/24/2018 11:56 am

		Description	Worksheet		Amount	
			CODE	Line No.		
			1.00	2.00	3.00	4.00
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS		1	74.00	0
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM		1	94.00	0
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1	74.00	0
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM		1	94.00	0
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS		1	74.00	0
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM		1	94.00	0
7.00		IV THERAPY & OP SERVICES		1	30.00	-692,803
8.00		IV THERAPY & OP SERVICES		1	31.00	-147,097
9.00		IV THERAPY & OP SERVICES		1	51.00	190,417
10.00		IV THERAPY & OP SERVICES		1	64.00	649,483

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018Worksheet C
Part I
Date/Time Prepared:
9/24/2018 11:56 am

			Title XVIII	Hospital	PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,739,447	17,739,447	0	17,739,447 30.00
31.00	03100	INTENSIVE CARE UNIT	3,558,007	3,558,007	0	3,558,007 31.00
43.00	04300	NURSERY	1,225,313	1,225,313	0	1,225,313 43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,608,840	5,608,840	0	5,608,840 50.00
51.00	05100	RECOVERY ROOM	2,558,860	2,558,860	0	2,558,860 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,179,604	2,179,604	0	2,179,604 52.00
53.00	05300	ANESTHESIOLOGY	223,417	223,417	0	223,417 53.00
53.01	05301	PAIN MANAGEMENT	564,990	564,990	0	564,990 53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,195,576	5,195,576	0	5,195,576 54.00
54.01	05401	ULTRASOUND	1,401,685	1,401,685	0	1,401,685 54.01
56.00	05600	RADIOISOTOPE	1,142,826	1,142,826	0	1,142,826 56.00
57.00	05700	CT SCAN	2,148,500	2,148,500	0	2,148,500 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,252,230	1,252,230	0	1,252,230 58.00
59.00	05900	CARDIAC CATHETERIZATION	2,857,954	2,857,954	0	2,857,954 59.00
60.00	06000	LABORATORY	8,617,445	8,617,445	0	8,617,445 60.00
64.00	06400	INTRAVENOUS THERAPY	649,483	649,483	0	649,483 64.00
65.00	06500	RESPIRATORY THERAPY	2,019,200	2,019,200	0	2,019,200 65.00
66.00	06600	PHYSICAL THERAPY	715,021	715,021	0	715,021 66.00
67.00	06700	OCCUPATIONAL THERAPY	162,802	162,802	0	162,802 67.00
68.00	06800	SPEECH PATHOLOGY	345,035	345,035	0	345,035 68.00
69.00	06900	ELECTROCARDIOLOGY	2,061,701	2,061,701	0	2,061,701 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	567,823	567,823	0	567,823 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,493,458	18,493,458	0	18,493,458 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,512,911	27,512,911	0	27,512,911 73.00
74.00	07400	RENAL DIALYSIS	251,547	251,547	0	251,547 74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0 75.00
75.01	07501	GI LAB	2,715,265	2,715,265	0	2,715,265 75.01
76.00	03950	DIABETIC EDUCATION	529,351	529,351	0	529,351 76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,306,587	1,306,587	0	1,306,587 76.98
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	23,067,978	23,067,978	0	23,067,978 90.00
91.00	09100	EMERGENCY	8,566,045	8,566,045	0	8,566,045 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,548,632	3,548,632	0	3,548,632 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,017,432	3,017,432	0	3,017,432 95.00
98.00	09850	HOME INFUSION	203,580	203,580	0	203,580 98.00
101.00	10100	HOME HEALTH AGENCY	2,259,721	2,259,721	0	2,259,721 101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				
200.00		Subtotal (see instructions)	154,268,266	154,268,266	0	154,268,266 200.00
201.00		Less Observation Beds	3,548,632	3,548,632	0	3,548,632 201.00
202.00		Total (see instructions)	150,719,634	150,719,634	0	150,719,634 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018Worksheet C
Part I
Date/Time Prepared:
9/24/2018 11:56 am

			Title XVIII			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	22,868,180		22,868,180			30.00	
31.00	03100	INTENSIVE CARE UNIT	5,330,406		5,330,406			31.00	
43.00	04300	NURSERY	3,204,402		3,204,402			43.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	14,604,687	31,605,446	46,210,133	0.121377	0.000000	50.00	
51.00	05100	RECOVERY ROOM	1,603,729	7,334,067	8,937,796	0.286297	0.000000	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,232,739	1,987,559	6,220,298	0.350402	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	6,983,445	10,499,785	17,483,230	0.012779	0.000000	53.00	
53.01	05301	PAIN MANAGEMENT	59,286	5,383,344	5,442,630	0.103808	0.000000	53.01	
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,498,869	26,516,277	30,015,146	0.173098	0.000000	54.00	
54.01	05401	ULTRASOUND	1,372,419	13,391,799	14,764,218	0.094938	0.000000	54.01	
56.00	05600	RADIOISOTOPE	1,043,788	12,225,761	13,269,549	0.086124	0.000000	56.00	
57.00	05700	CT SCAN	10,191,764	50,661,508	60,853,272	0.035306	0.000000	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,487,477	17,695,067	19,182,544	0.065280	0.000000	58.00	
59.00	05900	CARDIAC CATHETERIZATION	8,412,352	11,757,809	20,170,161	0.141692	0.000000	59.00	
60.00	06000	LABORATORY	20,559,128	81,468,995	102,028,123	0.084461	0.000000	60.00	
64.00	06400	INTRAVENOUS THERAPY	585,381	5,117,224	5,702,605	0.113892	0.000000	64.00	
65.00	06500	RESPIRATORY THERAPY	5,336,085	2,448,898	7,784,983	0.259371	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	1,285,279	168,009	1,453,288	0.492002	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	217,002	41,881	258,883	0.628863	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	105,153	372,743	477,896	0.721988	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	5,186,979	18,046,419	23,233,398	0.088739	0.000000	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	151,915	5,193,449	5,345,364	0.106227	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,589,124	10,832,053	21,421,177	0.863326	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	15,547,542	48,573,762	64,121,304	0.429076	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	382,027	31,269	413,296	0.608636	0.000000	74.00	
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00	
75.01	07501	GI LAB	2,094,121	23,541,404	25,635,525	0.105918	0.000000	75.01	
76.00	03950	DIABETIC EDUCATION	98	451,658	451,756	1.171763	0.000000	76.00	
76.98	07698	HYPERBARIC OXYGEN THERAPY	53,875	13,409,230	13,463,105	0.097049	0.000000	76.98	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	73,933	43,262,473	43,336,406	0.532300	0.000000	90.00	
91.00	09100	EMERGENCY	10,693,500	43,152,355	53,845,855	0.159085	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	617,699	5,972,204	6,589,903	0.538495	0.000000	92.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	892	5,833,918	5,834,810	0.517143	0.000000	95.00	
98.00	09850	HOME INFUSION	0	404,441	404,441	0.503361	0.000000	98.00	
101.00	10100	HOME HEALTH AGENCY	0	1,349,262	1,349,262			101.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	158,373,276	498,730,069	657,103,345			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	158,373,276	498,730,069	657,103,345			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018Worksheet C
Part I
Date/Time Prepared:
9/24/2018 11:56 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.121377		50.00
51.00	05100	RECOVERY ROOM	0.286297		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.350402		52.00
53.00	05300	ANESTHESIOLOGY	0.012779		53.00
53.01	05301	PAIN MANAGEMENT	0.103808		53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.173098		54.00
54.01	05401	ULTRASOUND	0.094938		54.01
56.00	05600	RADIOISOTOPE	0.086124		56.00
57.00	05700	CT SCAN	0.035306		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.065280		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.141692		59.00
60.00	06000	LABORATORY	0.084461		60.00
64.00	06400	INTRAVENOUS THERAPY	0.113892		64.00
65.00	06500	RESPIRATORY THERAPY	0.259371		65.00
66.00	06600	PHYSICAL THERAPY	0.492002		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.628863		67.00
68.00	06800	SPEECH PATHOLOGY	0.721988		68.00
69.00	06900	ELECTROCARDIOLOGY	0.088739		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.106227		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.863326		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.429076		73.00
74.00	07400	RENAL DIALYSIS	0.608636		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
75.01	07501	GI LAB	0.105918		75.01
76.00	03950	DIABETIC EDUCATION	1.171763		76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.097049		76.98
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.532300		90.00
91.00	09100	EMERGENCY	0.159085		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.538495		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.517143		95.00
98.00	09850	HOME INFUSION	0.503361		98.00
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018Worksheet D
Part I
Date/Time Prepared:
9/24/2018 11:56 am

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,214,369	0	1,214,369	14,522	83.62	30.00
31.00	INTENSIVE CARE UNIT	292,050		292,050	1,189	245.63	31.00
43.00	NURSERY	156,619		156,619	1,016	154.15	43.00
200.00	Total (lines 30 through 199)	1,663,038		1,663,038	16,727		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	6,769	566,024				30.00
31.00	INTENSIVE CARE UNIT	768	188,644				31.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	7,537	754,668				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018Worksheet D
Part II
Date/Time Prepared:
9/24/2018 11:56 am

				Title XVIII		Hospital	PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,089,482	46,210,133	0.023577	6,460,693	152,324	50.00
51.00	05100	RECOVERY ROOM	248,828	8,937,796	0.027840	841,421	23,425	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	238,745	6,220,298	0.038382	7,846	301	52.00
53.00	05300	ANESTHESIOLOGY	26,795	17,483,230	0.001533	3,315,875	5,083	53.00
53.01	05301	PAIN MANAGEMENT	55,693	5,442,630	0.010233	59,286	607	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	971,753	30,015,146	0.032375	2,267,086	73,397	54.00
54.01	05401	ULTRASOUND	129,734	14,764,218	0.008787	802,233	7,049	54.01
56.00	05600	RADIOISOTOPE	234,570	13,269,549	0.017677	589,389	10,419	56.00
57.00	05700	CT SCAN	219,696	60,853,272	0.003610	6,035,061	21,787	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	103,060	19,182,544	0.005373	881,946	4,739	58.00
59.00	05900	CARDIAC CATHETERIZATION	709,780	20,170,161	0.035190	4,040,298	142,178	59.00
60.00	06000	LABORATORY	524,133	102,028,123	0.005137	12,805,211	65,780	60.00
64.00	06400	INTRAVENOUS THERAPY	0	5,702,605	0.000000	412,825	0	64.00
65.00	06500	RESPIRATORY THERAPY	213,215	7,784,983	0.027388	3,663,436	100,334	65.00
66.00	06600	PHYSICAL THERAPY	25,179	1,453,288	0.017326	850,455	14,735	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,789	258,883	0.026224	120,003	3,147	67.00
68.00	06800	SPEECH PATHOLOGY	7,214	477,896	0.015095	81,246	1,226	68.00
69.00	06900	ELECTROCARDIOLOGY	156,295	23,233,398	0.006727	3,295,848	22,171	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	42,002	5,345,364	0.007858	109,937	864	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	336,429	21,421,177	0.015705	5,880,561	92,354	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	660,170	64,121,304	0.010296	9,392,293	96,703	73.00
74.00	07400	RENAL DIALYSIS	6,090	413,296	0.014735	286,083	4,215	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	07501	GI LAB	356,155	25,635,525	0.013893	1,426,338	19,816	75.01
76.00	03950	DIABETIC EDUCATION	26,845	451,756	0.059424	98	6	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	81,489	13,463,105	0.006053	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,410,748	43,336,406	0.055629	67,306	3,744	90.00
91.00	09100	EMERGENCY	1,132,968	53,845,855	0.021041	6,660,069	140,135	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	242,925	6,589,903	0.036863	401,003	14,782	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	HOME INFUSION	5,798	404,441	0.014336	0	0	98.00
200.00		Total (lines 50 through 199)	10,262,580	618,516,285		70,753,846	1,021,321	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0043		Period: From 05/01/2017 To 04/30/2018		Worksheet D Part III Date/Time Prepared: 9/24/2018 11:56 am	
					Title XVIII		Hospital		PPS	
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	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	14,522	0.00	6,769			30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,189	0.00	768			31.00
43.00	04300	NURSERY		0	1,016	0.00	0			43.00
200.00		Total (lines 30 through 199)		0	16,727		7,537			200.00
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost						
			9.00	13.00						
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0	0						31.00
43.00	04300	NURSERY	0	0						43.00
200.00		Total (lines 30 through 199)	0	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018Worksheet D
Part IV
Date/Time Prepared:
9/24/2018 11:56 am

Cost Center Description		Title XVIII			Hospital		PPS	
		Non Physician	Nursing School	Nursing School	Allied Health	Allied Health		
		Anesthetist Cost	Post-Stepdown Adjustments	Post-Stepdown Adjustments	Post-Stepdown Adjustments	Post-Stepdown Adjustments		
		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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
53.01	05301	PAIN MANAGEMENT	0	0	0	0	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
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
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	GI LAB	0	0	0	0	0	75.01
76.00	03950	DIABETIC EDUCATION	0	0	0	0	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
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
98.00	09850	HOME INFUSION	0	0	0	0	0	98.00
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: 14-0043		Period: From 05/01/2017 To 04/30/2018		Worksheet D Part IV Date/Time Prepared: 9/24/2018 11:56 am	
				Title XVIII		Hospital		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	46,210,133	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	8,937,796	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	6,220,298	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	17,483,230	0.000000	53.00
53.01	05301	PAIN MANAGEMENT		0	0	0	5,442,630	0.000000	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	30,015,146	0.000000	54.00
54.01	05401	ULTRASOUND		0	0	0	14,764,218	0.000000	54.01
56.00	05600	RADIOISOTOPE		0	0	0	13,269,549	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	60,853,272	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	19,182,544	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	20,170,161	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	102,028,123	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	5,702,605	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	7,784,983	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	1,453,288	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	258,883	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	477,896	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	23,233,398	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	5,345,364	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	21,421,177	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	64,121,304	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	413,296	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)		0	0	0	0	0.000000	75.00
75.01	07501	GI LAB		0	0	0	25,635,525	0.000000	75.01
76.00	03950	DIABETIC EDUCATION		0	0	0	451,756	0.000000	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	13,463,105	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	43,336,406	0.000000	90.00
91.00	09100	EMERGENCY		0	0	0	53,845,855	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	6,589,903	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
98.00	09850	HOME INFUSION		0	0	0	404,441	0.000000	98.00
200.00		Total (lines 50 through 199)		0	0	0	618,516,285		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018Worksheet D
Part IV
Date/Time Prepared:
9/24/2018 11:56 am

				Title XVIII		Hospital		PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			9.00	10.00	11.00	12.00	13.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	6,460,693	0	9,621,556	0	50.00	
51.00	05100	RECOVERY ROOM	0.000000	841,421	0	2,308,582	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	7,846	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.000000	3,315,875	0	2,775,356	0	53.00	
53.01	05301	PAIN MANAGEMENT	0.000000	59,286	0	4,335,620	0	53.01	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,267,086	0	7,999,304	0	54.00	
54.01	05401	ULTRASOUND	0.000000	802,233	0	3,786,831	0	54.01	
56.00	05600	RADIOISOTOPE	0.000000	589,389	0	4,756,537	0	56.00	
57.00	05700	CT SCAN	0.000000	6,035,061	0	18,887,781	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	881,946	0	5,183,965	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.000000	4,040,298	0	5,206,802	0	59.00	
60.00	06000	LABORATORY	0.000000	12,805,211	0	16,313,249	0	60.00	
64.00	06400	INTRAVENOUS THERAPY	0.000000	412,825	0	2,234,649	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0.000000	3,663,436	0	1,010,247	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.000000	850,455	0	92,348	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	120,003	0	8,495	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	81,246	0	9,922	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.000000	3,295,848	0	5,828,056	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	109,937	0	1,822,117	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	5,880,561	0	3,859,511	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	9,392,293	0	22,501,465	0	73.00	
74.00	07400	RENAL DIALYSIS	0.000000	286,083	0	13,080	0	74.00	
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00	
75.01	07501	GI LAB	0.000000	1,426,338	0	8,014,171	0	75.01	
76.00	03950	DIABETIC EDUCATION	0.000000	98	0	46,260	0	76.00	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	1,103,768	0	76.98	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	67,306	0	18,578,462	0	90.00	
91.00	09100	EMERGENCY	0.000000	6,660,069	0	12,050,981	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	401,003	0	2,311,173	0	92.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00	
98.00	09850	HOME INFUSION	0.000000	0	0	0	0	98.00	
200.00		Total (lines 50 through 199)		70,753,846	0	160,660,288	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018Worksheet D
Part IV
Date/Time Prepared:
9/24/2018 11:56 am

				Title XVIII	Hospital	PPS
Cost Center Description			PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost		
			21.00	24.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
53.01	05301	PAIN MANAGEMENT	0	0		53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
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
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
75.01	07501	GI LAB	0	0		75.01
76.00	03950	DIABETIC EDUCATION	0	0		76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0		90.00
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
98.00	09850	HOME INFUSION	0	0		98.00
200.00		Total (lines 50 through 199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018Worksheet D
Part V
Date/Time Prepared:
9/24/2018 11:56 am

			Title XVIII		Hospital		PPS	
	Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00			
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.121377	9,621,556	0	0	1,167,836	50.00
51.00	05100	RECOVERY ROOM	0.286297	2,308,582	0	0	660,940	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.350402	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.012779	2,775,356	0	0	35,466	53.00
53.01	05301	PAIN MANAGEMENT	0.103808	4,335,620	0	0	450,072	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.173098	7,999,304	0	0	1,384,664	54.00
54.01	05401	ULTRASOUND	0.094938	3,786,831	0	0	359,514	54.01
56.00	05600	RADIOISOTOPE	0.086124	4,756,537	0	0	409,652	56.00
57.00	05700	CT SCAN	0.035306	18,887,781	0	0	666,852	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.065280	5,183,965	0	0	338,409	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.141692	5,206,802	0	0	737,762	59.00
60.00	06000	LABORATORY	0.084461	16,313,249	4,880	0	1,377,833	60.00
64.00	06400	INTRAVENOUS THERAPY	0.113892	2,234,649	0	0	254,509	64.00
65.00	06500	RESPIRATORY THERAPY	0.259371	1,010,247	0	0	262,029	65.00
66.00	06600	PHYSICAL THERAPY	0.492002	92,348	0	0	45,435	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.628863	8,495	0	0	5,342	67.00
68.00	06800	SPEECH PATHOLOGY	0.721988	9,922	0	0	7,164	68.00
69.00	06900	ELECTROCARDIOLOGY	0.088739	5,828,056	0	0	517,176	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.106227	1,822,117	0	0	193,558	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.863326	3,859,511	0	0	3,332,016	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.429076	22,501,465	453	262,085	9,654,839	73.00
74.00	07400	RENAL DIALYSIS	0.608636	13,080	0	0	7,961	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	07501	GI LAB	0.105918	8,014,171	0	0	848,845	75.01
76.00	03950	DIABETIC EDUCATION	1.171763	46,260	0	0	54,206	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.097049	1,103,768	0	0	107,120	76.98
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.532300	18,578,462	0	95	9,889,315	90.00
91.00	09100	EMERGENCY	0.159085	12,050,981	0	0	1,917,130	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.538495	2,311,173	0	0	1,244,555	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.517143		0			95.00
98.00	09850	HOME INFUSION	0.503361	0	0	0	0	98.00
200.00		Subtotal (see instructions)		160,660,288	5,333	262,180	35,930,200	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		160,660,288	5,333	262,180	35,930,200	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0043		Period: From 05/01/2017 To 04/30/2018		Worksheet D Part V Date/Time Prepared: 9/24/2018 11:56 am	
				Title XVIII		Hospital		PPS	
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0					50.00
51.00	05100	RECOVERY ROOM	0	0					51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0					52.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
53.01	05301	PAIN MANAGEMENT	0	0					53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
54.01	05401	ULTRASOUND	0	0					54.01
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	412	0					60.00
64.00	06400	INTRAVENOUS THERAPY	0	0					64.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0					70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	194	112,454					73.00
74.00	07400	RENAL DIALYSIS	0	0					74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0					75.00
75.01	07501	GI LAB	0	0					75.01
76.00	03950	DIABETIC EDUCATION	0	0					76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0					76.98
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	51					90.00
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
98.00	09850	HOME INFUSION	0	0					98.00
200.00		Subtotal (see instructions)	606	112,505					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	606	112,505					202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0043	Period: From 05/01/2017 To 04/30/2018	Worksheet D-1 Date/Time Prepared: 9/24/2018 11:56 am	
		Title XVIII	Hospital	PPS	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			14,522	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			14,522	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)			11,617	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			6,769	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)			17,739,447	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)			17,739,447	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)			17,739,447	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)			1,221.56	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			8,268,740	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)			8,268,740	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018

Worksheet D-1

Date/Time Prepared:
9/24/2018 11:56 am

		Title XVIII		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,558,007	1,189	2,992.44	768	2,298,194
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					16,117,715
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					26,684,649
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					754,668
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,021,321
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,775,989
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					24,908,660
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)					2,905
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,221.56
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,548,632

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018

Worksheet D-1

Date/Time Prepared:
9/24/2018 11:56 am

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	1,214,369	17,739,447	0.068456	3,548,632	242,925	90.00
91.00 Nursing School cost	0	17,739,447	0.000000	3,548,632	0	91.00
92.00 Allied health cost	0	17,739,447	0.000000	3,548,632	0	92.00
93.00 All other Medical Education	0	17,739,447	0.000000	3,548,632	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0043	Period: From 05/01/2017 To 04/30/2018	Worksheet D-3 Date/Time Prepared: 9/24/2018 11:56 am
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		12,844,115	30.00
31.00	03100	INTENSIVE CARE UNIT		3,442,642	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.121377	6,460,693	50.00
51.00	05100	RECOVERY ROOM	0.286297	841,421	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.350402	7,846	52.00
53.00	05300	ANESTHESIOLOGY	0.012779	3,315,875	53.00
53.01	05301	PAIN MANAGEMENT	0.103808	59,286	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.173098	2,267,086	54.00
54.01	05401	ULTRASOUND	0.094938	802,233	54.01
56.00	05600	RADIOISOTOPE	0.086124	589,389	56.00
57.00	05700	CT SCAN	0.035306	6,035,061	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.065280	881,946	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.141692	4,040,298	59.00
60.00	06000	LABORATORY	0.084461	12,805,211	60.00
64.00	06400	INTRAVENOUS THERAPY	0.113892	412,825	64.00
65.00	06500	RESPIRATORY THERAPY	0.259371	3,663,436	65.00
66.00	06600	PHYSICAL THERAPY	0.492002	850,455	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.628863	120,003	67.00
68.00	06800	SPEECH PATHOLOGY	0.721988	81,246	68.00
69.00	06900	ELECTROCARDIOLOGY	0.088739	3,295,848	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.106227	109,937	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.863326	5,880,561	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.429076	9,392,293	73.00
74.00	07400	RENAL DIALYSIS	0.608636	286,083	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	75.00
75.01	07501	GI LAB	0.105918	1,426,338	75.01
76.00	03950	DIABETIC EDUCATION	1.171763	98	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.097049	0	76.98
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.532300	67,306	90.00
91.00	09100	EMERGENCY	0.159085	6,660,069	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.538495	401,003	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
98.00	09850	HOME INFUSION	0.503361	0	98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		70,753,846	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)		70,753,846	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0043	Period: From 05/01/2017 To 04/30/2018	Worksheet E Part A Date/Time Prepared: 9/24/2018 11:56 am
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		6,450,334	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		9,208,065	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)		277,446	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		1,828,392	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		85.04	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.96	30.00
31.00	Percentage of Medicaid patient days (see instructions)		17.54	31.00
32.00	Sum of lines 30 and 31		20.50	32.00
33.00	Allowable disproportionate share percentage (see instructions)		6.13	33.00
34.00	Disproportionate share adjustment (see instructions)		239,965	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0043	Period: From 05/01/2017 To 04/30/2018	Worksheet E Part A Date/Time Prepared: 9/24/2018 11:56 am
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)	5,977,483,147	6,766,695,164	35.00
35.01	Factor 3 (see instructions)	0.000090416	0.000093417	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	540,461	632,121	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	226,549	367,150	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	593,699		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 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	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)	16,769,509		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	19,154,180		48.00
		Amount		
		1.00		
49.00	Total payment for inpatient operating costs (see instructions)		18,558,012	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,289,065	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)		19,847,077	59.00
60.00	Primary payer payments		12,830	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		19,834,247	61.00
62.00	Deductibles billed to program beneficiaries		2,009,928	62.00
63.00	Coinsurance billed to program beneficiaries		12,993	63.00
64.00	Allowable bad debts (see instructions)		468,101	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		304,266	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		317,726	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		18,115,592	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)		1,329	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)		11,831	70.93
70.94	HRR adjustment amount (see instructions)		0	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018Worksheet E
Part A
Date/Time Prepared:
9/24/2018 11:56 am

		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96	
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97	
70.98	Low Volume Payment-3		0	70.98	
70.99	HAC adjustment amount (see instructions)		0	70.99	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		18,128,752	71.00	
71.01	Sequestration adjustment (see instructions)		362,575	71.01	
71.02	Demonstration payment adjustment amount after sequestration		0	71.02	
72.00	Interim payments		17,832,687	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)		-66,510	74.00	
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00	
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00	
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00	
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00	
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00	
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00	
95.00	Time value of money for operating expenses (see instructions)		0	95.00	
96.00	Time value of money for capital related expenses (see instructions)		0	96.00	
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)	749,701	1,038,802	100.00	
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)	0.9997087410	1.0014889132	101.00	
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	-218	1,547	102.00	
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)	1.0000	1.0000	103.00	
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00	
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00	
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00	
202.00	Medicare discharges (see instructions)			202.00	
203.00	Case-mix adjustment factor (see instructions)			203.00	
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount			204.00	
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00	
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00	
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00	
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00	
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00	
210.00	Reserved for future use			210.00	
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00	
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: 14-0043

Period:
From 05/01/2017
To 04/30/2018

Worksheet DSH

Date/Time Prepared:
9/24/2018 11:56 am

		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)	2.96	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	17.54	0.00			17.54	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	20.50	0.00			17.54	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	RRC				RRC	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	85.04	0.00			85.04	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	6.13	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)?	No				No	9.00
10.00	S-2, Line 45	No				No	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)	0.00	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)	1,746	0			1,746	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	502	0			502	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	107	0			107	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	103	0			103	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	2,458	0			2,458	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	13,822	0			13,822	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	194	0			194	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)	14,016	0			14,016	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	17.54	0.00			17.54	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 14-0043		Period: From 05/01/2017 To 04/30/2018		Worksheet DSH Date/Time Prepared: 9/24/2018 11:56 am	
		Title XVIII		Hospital		PPS	
		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE							
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	6.13		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		6.13		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.		6.13		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")	True				True	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	True				True	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)	Rural				Rural	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018

Worksheet DSH

Date/Time Prepared:
9/24/2018 11:56 am

Title XVIII

Hospital

PPS

		Revised		
		Percentage		
		6.00		
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE			
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	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	4.15		29.00
30.00	Line 28 or 29 as applicable	4.15		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: 14-0043	Period: From 05/01/2017 To 04/30/2018	Worksheet E Part B Date/Time Prepared: 9/24/2018 11:56 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		113,111	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		35,930,200	2.00
3.00	OPPS payments		29,126,820	3.00
4.00	Outlier payment (see instructions)		510,906	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)		113,111	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		267,513	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)		267,513	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)		267,513	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		154,402	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)		113,111	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)		29,637,726	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		6,024,250	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)		23,726,587	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)		23,726,587	30.00
31.00	Primary payer payments		3,246	31.00
32.00	Subtotal (line 30 minus line 31)		23,723,341	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)		1,002,640	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		651,716	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		800,881	36.00
37.00	Subtotal (see instructions)		24,375,057	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-181	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)		24,375,238	40.00
40.01	Sequestration adjustment (see instructions)		487,505	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		23,791,807	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		95,926	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: 14-0043

Period:
From 05/01/2017
To 04/30/2018Worksheet E
Part B
Date/Time Prepared:
9/24/2018 11:56 am

Title XVIII

Hospital

PPS

Overrides

1.00

WORKSHEET OVERRIDE VALUES

112.00 Override of Ancillary service charges (line 12)

0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018Worksheet E-1
Part I
Date/Time Prepared:
9/24/2018 11:56 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		17,913,478		23,848,948	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	11/09/2017	80,791	11/09/2017	57,141	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)		-80,791		-57,141	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)		17,832,687		23,791,807	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		95,926	6.01	
6.02	SETTLEMENT TO PROGRAM		66,510		0	6.02	
7.00	Total Medicare program liability (see instructions)		17,766,177		23,887,733	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: 14-0043

Period:

Worksheet E-1

Component CCN: 14-U043

From 05/01/2017
To 04/30/2018Part I
Date/Time Prepared:
9/24/2018 11:56 am

		Title XVIII		Swing Beds - SNF		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		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		0		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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		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: 14-0043	Period: From 05/01/2017 To 04/30/2018	Worksheet E-1 Part II Date/Time Prepared: 9/24/2018 11:56 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-0043

Period:

Worksheet E-2

Component CCN: 14-U043

From 05/01/2017
To 04/30/2018Date/Time Prepared:
9/24/2018 11:56 am

		Title XVIII	Swing Beds - SNF	PPS	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		0	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)				3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		0	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		0	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		0	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		0	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		0	0	19.00
19.01	Sequestration adjustment (see instructions)		0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
20.00	Interim payments		0	0	20.00
21.00	Tentative settlement (for contractor use only)		0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		0	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
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 swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

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

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018

Worksheet G

Date/Time Prepared:
9/24/2018 11:56 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	34,738,574	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	25,721,962	0	0	0	4.00
5.00	Other receivable	1,884,736	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	4,249,574	0	0	0	7.00
8.00	Prepaid expenses	2,414,971	0	0	0	8.00
9.00	Other current assets	2,729,877	0	0	0	9.00
10.00	Due from other funds	139,407	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	71,879,101	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,724,440	0	0	0	12.00
13.00	Land improvements	4,184,203	0	0	0	13.00
14.00	Accumulated depreciation	-2,705,053	0	0	0	14.00
15.00	Buildings	91,081,103	0	0	0	15.00
16.00	Accumulated depreciation	-54,449,898	0	0	0	16.00
17.00	Leasehold improvements	13,183,198	0	0	0	17.00
18.00	Accumulated depreciation	-11,732,763	0	0	0	18.00
19.00	Fixed equipment	524,004	0	0	0	19.00
20.00	Accumulated depreciation	-375,975	0	0	0	20.00
21.00	Automobiles and trucks	476,099	0	0	0	21.00
22.00	Accumulated depreciation	-416,677	0	0	0	22.00
23.00	Major movable equipment	68,798,440	0	0	0	23.00
24.00	Accumulated depreciation	-49,256,306	0	0	0	24.00
25.00	Minor equipment depreciable	14,601,333	0	0	0	25.00
26.00	Accumulated depreciation	-12,774,335	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	6,733,126	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	70,594,939	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	73,181,353	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	18,909,462	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	92,090,815	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	234,564,855	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	4,890,844	0	0	0	37.00
38.00	Salaries, wages, and fees payable	10,972,527	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,830,000	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	15,488,266	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	34,181,637	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	13,341,401	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	59,756,401	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	73,097,802	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	107,279,439	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	127,285,416				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)	127,285,416	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	234,564,855	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018

Worksheet G-1

Date/Time Prepared:
9/24/2018 11:56 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		116,891,758		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		10,393,658				2.00
3.00	Total (sum of line 1 and line 2)		127,285,416		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		127,285,416		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		127,285,416		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018Worksheet G-2
Parts I & II
Date/Time Prepared:
9/24/2018 11:56 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	26,072,582		26,072,582	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	26,072,582		26,072,582	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,330,406		5,330,406	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)	5,330,406		5,330,406	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	31,402,988		31,402,988	17.00
18.00	Ancillary services	115,584,264	398,755,416	514,339,680	18.00
19.00	Outpatient services	11,385,132	92,387,032	103,772,164	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		1,349,262	1,349,262	22.00
23.00	AMBULANCE SERVICES	892	5,833,918	5,834,810	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	12,253,308	139,651,797	151,905,105	27.00
27.01	PHYSICIANS' PRIVATE OFFICES	0	8,621,887	8,621,887	27.01
27.02	PT/OT/ST NON-PROVIDER BASED	0	8,521,627	8,521,627	27.02
27.03	HOME INFUSION	0	404,441	404,441	27.03
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	170,626,584	655,525,380	826,151,964	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		217,759,746		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	INTEREST EXPENSE	448,053			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)		448,053		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		217,311,693		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0043

Period:
From 05/01/2017
To 04/30/2018

Worksheet G-3

Date/Time Prepared:
9/24/2018 11:56 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	826,151,964	1.00
2.00	Less contractual allowances and discounts on patients' accounts	604,693,439	2.00
3.00	Net patient revenues (line 1 minus line 2)	221,458,525	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	217,311,693	4.00
5.00	Net income from service to patients (line 3 minus line 4)	4,146,832	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	49,788	6.00
7.00	Income from investments	1,831,835	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	165,029	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	6,682	13.00
14.00	Revenue from meals sold to employees and guests	804,067	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	2,082,823	17.00
18.00	Revenue from sale of medical records and abstracts	82,103	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	64,346	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	176,334	22.00
23.00	Governmental appropriations	307,710	23.00
24.00	CHANGE IN NET EQUITY OF AFFILIATES	548,772	24.00
24.01	DAYCARE REVENUE	500,749	24.01
24.02	EHR REVENUE	99,485	24.02
24.03	MISCELLANEOUS INCOME	381,765	24.03
25.00	Total other income (sum of lines 6-24)	7,101,488	25.00
26.00	Total (line 5 plus line 25)	11,248,320	26.00
27.00	CHANGE IN NET EQUITY OF INVESTEES	169,420	27.00
27.01	INTEREST EXPENSE	448,053	27.01
27.02	LOSS ON SALE OF ASSET	187,092	27.02
27.03	PROVISION FOR INCOME TAXES	-301,747	27.03
27.04	DONATION EXPENSES	351,844	27.04
28.00	Total other expenses (sum of line 27 and subscripts)	854,662	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	10,393,658	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0043

Period:

Worksheet H

HHA CCN: 14-7562

From 05/01/2017
To 04/30/2018Date/Time Prepared:
9/24/2018 11:56 amHome Health
Agency I

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	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures		0		0	0	1.00
2.00	Capital Related - Movable Equipment		0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	180,791	0	19,773	0	143,400	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	660,062	0	0	0	660,062	6.00
7.00	Physical Therapy	161,271	0	0	52,828	214,099	7.00
8.00	Occupational Therapy	0	0	0	8,645	8,645	8.00
9.00	Speech Pathology	4,145	0	0	0	4,145	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	25,987	0	0	0	25,987	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,032,256	0	19,773	61,473	1,256,902	24.00
	Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0		1.00
2.00	Capital Related - Movable Equipment	0	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation	0	0	0	0		4.00
5.00	Administrative and General	-36,759	307,205	0	307,205		5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	660,062	0	660,062		6.00
7.00	Physical Therapy	0	214,099	0	214,099		7.00
8.00	Occupational Therapy	0	8,645	0	8,645		8.00
9.00	Speech Pathology	0	4,145	0	4,145		9.00
10.00	Medical Social Services	0	0	0	0		10.00
11.00	Home Health Aide	0	25,987	0	25,987		11.00
12.00	Supplies (see instructions)	0	0	0	0		12.00
13.00	Drugs	0	0	0	0		13.00
14.00	DME	0	0	0	0		14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0	0		17.00
18.00	Clinic	0	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0	0		19.00
20.00	Day Care Program	0	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0	0		21.00
22.00	Homemaker Service	0	0	0	0		22.00
23.00	All Others (specify)	0	0	0	0		23.00
23.50	Telemedicine	0	0	0	0		23.50
24.00	Total (sum of lines 1-23)	-36,759	1,220,143	0	1,220,143		24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 14-0043

Period:

Worksheet H-1

HHA CCN: 14-7562

From 05/01/2017
To 04/30/2018Part I
Date/Time Prepared:
9/24/2018 11:56 amHome Health
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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
			Bldgs & Fixtures	Movable Equipment				
			0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	307,205	0	0	0	0	307,205	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	660,062	0	0	0	0	660,062	6.00
7.00	Physical Therapy	214,099	0	0	0	0	214,099	7.00
8.00	Occupational Therapy	8,645	0	0	0	0	8,645	8.00
9.00	Speech Pathology	4,145	0	0	0	0	4,145	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	25,987	0	0	0	0	25,987	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,220,143	0	0	0	0	1,220,143	24.00
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00	Transportation							4.00
5.00	Administrative and General	307,205						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	222,111	882,173					6.00
7.00	Physical Therapy	72,045	286,144					7.00
8.00	Occupational Therapy	2,909	11,554					8.00
9.00	Speech Pathology	1,395	5,540					9.00
10.00	Medical Social Services	0	0					10.00
11.00	Home Health Aide	8,745	34,732					11.00
12.00	Supplies (see instructions)	0	0					12.00
13.00	Drugs	0	0					13.00
14.00	DME	0	0					14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00	Private Duty Nursing	0	0					17.00
18.00	Clinic	0	0					18.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program	0	0					20.00
21.00	Home Delivered Meals Program	0	0					21.00
22.00	Homemaker Service	0	0					22.00
23.00	All Others (specify)	0	0					23.00
23.50	Telemedicine	0	0					23.50
24.00	Total (sum of lines 1-23)		1,220,143					24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-0043

Period:

Worksheet H-1

HHA CCN: 14-7562

From 05/01/2017
To 04/30/2018Part II
Date/Time Prepared:
9/24/2018 11:56 amHome Health
Agency I

PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00	3.00	4.00	5A.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-307,205	912,938 5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	660,062	6.00
7.00	Physical Therapy	0	0	0	0	214,099	7.00
8.00	Occupational Therapy	0	0	0	0	8,645	8.00
9.00	Speech Pathology	0	0	0	0	4,145	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	25,987	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-307,205	912,938 24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0	307,205	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.336501 26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0043

Period:

Worksheet H-2

HHA CCN: 14-7562

From 05/01/2017

Part I

To 04/30/2018

Date/Time Prepared:

9/24/2018 11:56 am

Home Health

PPS

Agency I

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			BLDG & FIXT	MVBLE EQUIP				
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	21,344	25,091	84,366	130,801	29,709	1.00
2.00	Skilled Nursing Care	882,173	0	0	308,017	1,190,190	270,332	2.00
3.00	Physical Therapy	286,144	0	0	75,257	361,401	82,086	3.00
4.00	Occupational Therapy	11,554	0	0	0	11,554	2,624	4.00
5.00	Speech Pathology	5,540	0	0	1,934	7,474	1,698	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	34,732	0	0	12,127	46,859	10,643	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,220,143	21,344	25,091	481,701	1,748,279	397,092	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00
Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	28,894	0	17,851	0	3,137	32,084	1.00
2.00	Skilled Nursing Care	0	0	0	0	17,414	0	2.00
3.00	Physical Therapy	0	0	0	0	3,389	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	90	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	1,821	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	28,894	0	17,851	0	25,851	32,084	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0043

Period:

Worksheet H-2

HHA CCN: 14-7562

From 05/01/2017
To 04/30/2018Part I
Date/Time Prepared:
9/24/2018 11:56 amHome Health
Agency I

PPS

Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	0	0	9,670	252,146	0	252,146	1.00
2.00	Skilled Nursing Care	0	0	0	1,477,936	0	1,477,936	2.00
3.00	Physical Therapy	0	0	0	446,876	0	446,876	3.00
4.00	Occupational Therapy	0	0	0	14,178	0	14,178	4.00
5.00	Speech Pathology	0	0	0	9,262	0	9,262	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	59,323	0	59,323	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	9,670	2,259,721	0	2,259,721	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Allocated HHA A&G (see Part II)	Total HHA Costs					
		27.00	28.00					
1.00	Administrative and General							1.00
2.00	Skilled Nursing Care	185,625	1,663,561					2.00
3.00	Physical Therapy	56,126	503,002					3.00
4.00	Occupational Therapy	1,781	15,959					4.00
5.00	Speech Pathology	1,163	10,425					5.00
6.00	Medical Social Services	0	0					6.00
7.00	Home Health Aide	7,451	66,774					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
19.50	Telemedicine	0	0					19.50
20.00	Total (sum of lines 1-19) (2)	252,146	2,259,721					20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.125597						21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0043

Period:

Worksheet H-2

HHA CCN: 14-7562

From 05/01/2017
To 04/30/2018Part II
Date/Time Prepared:
9/24/2018 11:56 amHome Health
Agency I

PPS

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
		1.00	2.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	2,320	24,774	180,791	0	130,801	2,320	1.00
2.00	Skilled Nursing Care	0	0	660,062	0	1,190,190	0	2.00
3.00	Physical Therapy	0	0	161,271	0	361,401	0	3.00
4.00	Occupational Therapy	0	0	0	0	11,554	0	4.00
5.00	Speech Pathology	0	0	4,145	0	7,474	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	25,987	0	46,859	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	2,320	24,774	1,032,256		1,748,279	2,320	20.00
21.00	Total cost to be allocated	21,344	25,091	481,701		397,092	28,894	21.00
22.00	Unit cost multiplier	9.200000	1.012796	0.466649		0.227133	12.454310	22.00
Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	2,320	0	174	29,837	0	1.00
2.00	Skilled Nursing Care	0	0	0	966	0	0	2.00
3.00	Physical Therapy	0	0	0	188	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	5	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	101	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	2,320	0	1,434	29,837	0	20.00
21.00	Total cost to be allocated	0	17,851	0	25,851	32,084	0	21.00
22.00	Unit cost multiplier	0.000000	7.694397	0.000000	18.027197	1.075309	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0043

Period:

Worksheet H-2

HHA CCN: 14-7562

From 05/01/2017
To 04/30/2018Part II
Date/Time Prepared:
9/24/2018 11:56 amHome Health
Agency I

PPS

Cost Center Description		PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
		15.00	16.00		
1.00	Administrative and General	0	1,349,262		1.00
2.00	Skilled Nursing Care	0	0		2.00
3.00	Physical Therapy	0	0		3.00
4.00	Occupational Therapy	0	0		4.00
5.00	Speech Pathology	0	0		5.00
6.00	Medical Social Services	0	0		6.00
7.00	Home Health Aide	0	0		7.00
8.00	Supplies (see instructions)	0	0		8.00
9.00	Drugs	0	0		9.00
10.00	DME	0	0		10.00
11.00	Home Dialysis Aide Services	0	0		11.00
12.00	Respiratory Therapy	0	0		12.00
13.00	Private Duty Nursing	0	0		13.00
14.00	Clinic	0	0		14.00
15.00	Health Promotion Activities	0	0		15.00
16.00	Day Care Program	0	0		16.00
17.00	Home Delivered Meals Program	0	0		17.00
18.00	Homemaker Service	0	0		18.00
19.00	All Others (specify)	0	0		19.00
19.50	Telemedicine	0	0		19.50
20.00	Total (sum of lines 1-19)	0	1,349,262		20.00
21.00	Total cost to be allocated	0	9,670		21.00
22.00	Unit cost multiplier	0.000000	0.007167		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0043

Period:

Worksheet H-3

HHA CCN: 14-7562

From 05/01/2017
To 04/30/2018Part I
Date/Time Prepared:
9/24/2018 11:56 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	1,663,561		1,663,561	4,383	379.55	1.00
2.00	Physical Therapy	3.00	503,002	0	503,002	1,941	259.15	2.00
3.00	Occupational Therapy	4.00	15,959	0	15,959	99	161.20	3.00
4.00	Speech Pathology	5.00	10,425	0	10,425	52	200.48	4.00
5.00	Medical Social Services	6.00	0	0	0	0	0.00	5.00
6.00	Home Health Aide	7.00	66,774	0	66,774	202	330.56	6.00
7.00	Total (sum of lines 1-6)		2,259,721	0	2,259,721	6,677		7.00
				Program Visits				
				Part B				
				Not Subject to Deductibles & Coinsurance		Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
Limitation Cost Computation								
8.00	Skilled Nursing Care		99914	0	1,475			8.00
9.00	Physical Therapy		99914	0	847			9.00
10.00	Occupational Therapy		99914	0	50			10.00
11.00	Speech Pathology		99914	0	50			11.00
12.00	Medical Social Services		99914	0	0			12.00
13.00	Home Health Aide		99914	0	184			13.00
14.00	Total (sum of lines 8-13)			0	2,606			14.00
		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	0	8,751	8,751	10,136	0.863358	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00
				Program Visits		Cost of Services		
				Part B		Part B		
				Not Subject to Deductibles & Coinsurance		Subject to Deductibles & Coinsurance		
		6.00	7.00	8.00	9.00	10.00	11.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	0	1,475		0	559,836		1.00
2.00	Physical Therapy	0	847		0	219,500		2.00
3.00	Occupational Therapy	0	50		0	8,060		3.00
4.00	Speech Pathology	0	50		0	10,024		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	184		0	60,823		6.00
7.00	Total (sum of lines 1-6)	0	2,606		0	858,243		7.00
		6.00	7.00	8.00	9.00	10.00	11.00	
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0043

Period:

Worksheet H-3

HHA CCN: 14-7562

From 05/01/2017
To 04/30/2018Part I
Date/Time Prepared:
9/24/2018 11:56 am

Title XVIII

Home Health
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Cost Center Description		Program Covered Charges			Cost of Services	Agency 1		
		Part A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
			6.00	7.00		8.00	9.00	10.00
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	8,863	0	0	7,652	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00
Cost Center Description		Total Program Cost (sum of cols. 9-10)						
		12.00						
		PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
Cost Per Visit Computation								
1.00	Skilled Nursing Care	559,836						1.00
2.00	Physical Therapy	219,500						2.00
3.00	Occupational Therapy	8,060						3.00
4.00	Speech Pathology	10,024						4.00
5.00	Medical Social Services	0						5.00
6.00	Home Health Aide	60,823						6.00
7.00	Total (sum of lines 1-6)	858,243						7.00
Cost Center Description								
		12.00						
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0043

Period:

Worksheet H-3

HHA CCN: 14-7562

From 05/01/2017
To 04/30/2018Part II
Date/Time Prepared:
9/24/2018 11:56 am

Title XVIII

Home Health
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PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.492002	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.628863	0	0	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.721988	0	0	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.863326	10,136	8,751	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.429076	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0043

Period:

Worksheet H-4

HHA CCN: 14-7562

From 05/01/2017
To 04/30/2018Part I-II
Date/Time Prepared:
9/24/2018 11:56 am

Title XVIII

Home Health
Agency I

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		Agency 1		Agency 2		
		Part A	Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
		1.00	2.00	3.00		
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES						
Reasonable Cost of Part A & Part B Services						
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00	
2.00	Total charges	0	0	0	2.00	
Customary Charges						
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00	
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00	
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00	
6.00	Total customary charges (see instructions)	0	0	0	6.00	
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00	
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00	
9.00	Primary payer amounts	0	0	0	9.00	
			Part A Services	Part B Services		
			1.00	2.00		
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT						
10.00	Total reasonable cost (see instructions)		0	0	10.00	
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	496,223	11.00	
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	0	12.00	
13.00	Total PPS Reimbursement - LUPA Episodes		0	25,957	13.00	
14.00	Total PPS Reimbursement - PEP Episodes		0	5,857	14.00	
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	23,331	15.00	
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0	16.00	
17.00	Total Other Payments		0	0	17.00	
18.00	DME Payments		0	0	18.00	
19.00	Oxygen Payments		0	0	19.00	
20.00	Prosthetic and Orthotic Payments		0	0	20.00	
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0	21.00	
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	551,368	22.00	
23.00	Excess reasonable cost (from line 8)		0	0	23.00	
24.00	Subtotal (line 22 minus line 23)		0	551,368	24.00	
25.00	Coinsurance billed to program patients (from your records)		0	0	25.00	
26.00	Net cost (line 24 minus line 25)		0	551,368	26.00	
27.00	Reimbursable bad debts (from your records)				27.00	
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)				28.00	
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	551,368	29.00	
30.00	PS&R OTHER ADJUSTMENTS		0	-1,610	30.00	
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	30.50	
30.99	Demonstration payment adjustment amount before sequestration		0	0	30.99	
31.00	Subtotal (see instructions)		0	549,758	31.00	
31.01	Sequestration adjustment (see instructions)		0	10,995	31.01	
31.02	Demonstration payment adjustment amount after sequestration		0	0	31.02	
32.00	Interim payments (see instructions)		0	538,763	32.00	
33.00	Tentative settlement (for contractor use only)		0	0	33.00	
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0	34.00	
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	35.00	

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED
TO PROGRAM BENEFICIARIES

Provider CCN: 14-0043

Period:

Worksheet H-5

HHA CCN: 14-7562

From 05/01/2017
To 04/30/2018Date/Time Prepared:
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		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		538,763	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			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			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. H-4, Part II, column as appropriate, line 32)		0		538,763	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			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		538,763	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0043	Period: From 05/01/2017 To 04/30/2018	Worksheet L Parts I-III Date/Time Prepared: 9/24/2018 11:56 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,264,098	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		24,967	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)		35.62	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)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		1,289,065	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