

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: 14-0143	Period: From 10/01/2017 To 09/30/2018	Worksheet S Parts I-III Date/Time Prepared: 2/27/2019 1:34 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 2/27/2019	Time: 1:34 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 ST. MARGARET'S HOSPITAL (14-0143) for the cost reporting period beginning 10/01/2017 and ending 09/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-167,690	-6,696	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	41	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
200.00	Total	0	-167,649	-6,696	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: 14-0143		Period: From 10/01/2017 To 09/30/2018		Worksheet S-2 Part I Date/Time Prepared: 2/27/2019 1:34 pm	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 600 EAST FIRST ST			PO Box:				1.00		
2.00	City: SPRING VALLEY			State: IL		Zip Code: 61362		County: BUREAU		
		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		ST. MARGARET'S HOSPITAL	140143	99914	1	07/01/1966	N	P	P
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		ST. MARGARET'S HOSPITAL	14U143	99914		06/23/2003	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									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice		ST. MARGARET'S HOSPITAL	141595	99914		07/07/1998			
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)						10/01/2017	09/30/2018		20.00
21.00	Type of Control (see instructions)						1			21.00
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	N		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		N	22.03
23.00	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.					2	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.			634	0	0	0	313	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0143

Period:
From 10/01/2017
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Part I
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		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
						Urban/Rural S	Date of Geogr	
						1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					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)							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.					10/01/2017	09/30/2018	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), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
						V	XVIII	XIX
						1.00	2.00	3.00
Prospective Payment System (PPS)-Capital								
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	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.							
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		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet S-2
Part I
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	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00		2.00	3.00	4.00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
	Unweighted FTEs Nonprovider Site		Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
	1.00		2.00	3.00		
64.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

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

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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	Speech	Respiratory		
			1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			N	N	N	N	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: 14-0143	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part I Date/Time Prepared: 2/27/2019 1:34 pm	
			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
			1.00	2.00	3.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	442,968	0		118.01
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		Y	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		35H002	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0143		Period: From 10/01/2017 To 09/30/2018		Worksheet S-2 Part I Date/Time Prepared: 2/27/2019 1:34 pm		
1.00		2.00		3.00						
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.										
141.00	Name: SISTERS MARY OF THE PRESENTATION HC		Contractor's Name: NORIDIAN ADMIN SVC		Contractor's Number: 03001				141.00	
142.00	Street: 1202 PAGE DR SW PO BOX 10007		PO Box:						142.00	
143.00	City: FARGO		State: ND		Zip Code:		58106-0007		143.00	
									1.00	
144.00 Are provider based physicians' costs included in Worksheet A?									Y	
									1.00	
									2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.								145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N				146.00	
									1.00	
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.									N	
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.									N	
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.									N	
				Part A	Part B	Title V	Title XIX			
				1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital			N	N	N	N			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	
				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	
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	
168.01 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	
						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)						10/01/2017	09/30/2018		170.00	
						1.00	2.00			
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N		0		

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0143	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part II Date/Time Prepared: 2/27/2019 1:34 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		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.		Y	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	01/25/2019	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	Y		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet S-2
Part II
Date/Time Prepared:
2/27/2019 1:34 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	PIP PYMTS WERE ENTERED AS PAYMENT.	Y	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				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				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.				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.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				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.	DON	TROGLIO		41.00
42.00	Enter the employer/company name of the cost report preparer.	ST. MARGARET'S HOSPITAL			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	815-664-1328	DTRUGLIO@ABOUTSMG.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet S-2
Part II
Date/Time Prepared:
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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 OF ACCOUNTING	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet S-3
Part I
Date/Time Prepared:
2/27/2019 1:34 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	38	13,870	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)		38	13,870	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	6	2,190	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)		44	16,060	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		44				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet S-3
Part I
Date/Time Prepared:
2/27/2019 1:34 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	3,307	378	5,519			1.00
2.00	HMO and other (see instructions)	843	313				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	15	0	15			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,322	378	5,534			7.00
8.00	INTENSIVE CARE UNIT	513	20	808			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		210	640			13.00
14.00	Total (see instructions)	3,835	608	6,982	0.00	581.70	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	8.59	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	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	590.29	27.00
28.00	Observation Bed Days		513	2,535			28.00
29.00	Ambulance Trips	742					29.00
30.00	Employee discount days (see instruction)			20			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	26	129			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: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet S-3
Part I
Date/Time Prepared:
2/27/2019 1:34 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,040	276	1,948	1.00
2.00 HMO and other (see instructions)			181	127		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,040	276	1,948	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					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: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet S-3
Part II
Date/Time Prepared:
2/27/2019 1:34 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	37,526,848	766,175	38,293,023	1,228,746.27	31.16	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	8,450	8,450	54.00	156.48	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		8,289,480	757,725	9,047,205	50,959.00	177.54	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)		1,232,046	130,951	1,362,997	54,878.80	24.84	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,077,674	0	1,077,674	15,285.35	70.50	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		1,107,675	0	1,107,675	4,511.96	245.50	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		1,121,426	0	1,121,426	8,438.00	132.90	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		6,726,596	0	6,726,596			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		282,337	0	282,337			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		291,122	0	291,122			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)		253,175	0	253,175			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	223,382	0	223,382	8,320.50	26.85	26.00
27.00	Administrative & General	5.00	3,118,758	-130,951	2,987,807	133,401.76	22.40	27.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet S-3
Part II
Date/Time Prepared:
2/27/2019 1:34 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		225,487	0	225,487	783.55	287.78	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	570,605	0	570,605	24,284.10	23.50	30.00
31.00	Laundry & Linen Service	8.00	0	39,672	39,672	3,212.75	12.35	31.00
32.00	Housekeeping	9.00	554,158	-39,672	514,486	37,845.17	13.59	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	828,553	-620,669	207,884	13,172.05	15.78	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	620,669	620,669	39,327.15	15.78	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,140,694	0	1,140,694	28,399.76	40.17	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	1,460,524	0	1,460,524	52,759.85	27.68	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: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet S-3
Part III
Date/Time Prepared:
2/27/2019 1:34 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	29,462,855	8,450	29,471,305	1,178,570.82	25.01	1.00
2.00	Excluded area salaries (see instructions)	1,232,046	130,951	1,362,997	54,878.80	24.84	2.00
3.00	Subtotal salaries (line 1 minus line 2)	28,230,809	-122,501	28,108,308	1,123,692.02	25.01	3.00
4.00	Subtotal other wages & related costs (see inst.)	3,306,775	0	3,306,775	28,235.31	117.11	4.00
5.00	Subtotal wage-related costs (see inst.)	6,979,771	0	6,979,771	0.00	24.83	5.00
6.00	Total (sum of lines 3 thru 5)	38,517,355	-122,501	38,394,854	1,151,927.33	33.33	6.00
7.00	Total overhead cost (see instructions)	8,122,161	-130,951	7,991,210	341,506.64	23.40	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0143	Period: From 10/01/2017 To 09/30/2018	Worksheet S-3 Part IV Date/Time Prepared: 2/27/2019 1:34 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		837,128	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		3,442,797	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		215,226	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		38,254	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		3,596	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		215,930	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		47,673	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		1,920,166	17.00
18.00	Medicare Taxes - Employers Portion Only		541,704	18.00
19.00	Unemployment Insurance		18,073	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		19,509	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		7,300,056	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: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet S-3
Part V
Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	1,389,429	7,300,056	1.00
2.00	Hospital	1,389,429	7,300,056	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			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018

Worksheet S-7

Date/Time Prepared:
2/27/2019 1:34 pm

		1.00	2.00	3.00	4.00
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	Y			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	06/23/2003		2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	0	0	0 3.00
4.00		RUL	0	0	0 4.00
5.00		RVX	0	0	0 5.00
6.00		RVL	0	0	0 6.00
7.00		RHX	0	0	0 7.00
8.00		RHL	0	0	0 8.00
9.00		RMX	0	0	0 9.00
10.00		RML	0	0	0 10.00
11.00		RLX	0	0	0 11.00
12.00		RUC	0	0	0 12.00
13.00		RUB	0	0	0 13.00
14.00		RUA	0	0	0 14.00
15.00		RVC	0	0	0 15.00
16.00		RVB	0	0	0 16.00
17.00		RVA	0	0	0 17.00
18.00		RHC	0	0	0 18.00
19.00		RHB	0	0	0 19.00
20.00		RHA	0	0	0 20.00
21.00		RMC	0	0	0 21.00
22.00		RMB	0	0	0 22.00
23.00		RMA	0	0	0 23.00
24.00		RLB	0	0	0 24.00
25.00		RLA	0	0	0 25.00
26.00		ES3	0	0	0 26.00
27.00		ES2	0	0	0 27.00
28.00		ES1	0	15	15 28.00
29.00		HE2	0	0	0 29.00
30.00		HE1	0	0	0 30.00
31.00		HD2	0	0	0 31.00
32.00		HD1	0	0	0 32.00
33.00		HC2	0	0	0 33.00
34.00		HC1	0	0	0 34.00
35.00		HB2	0	0	0 35.00
36.00		HB1	0	0	0 36.00
37.00		LE2	0	0	0 37.00
38.00		LE1	0	0	0 38.00
39.00		LD2	0	0	0 39.00
40.00		LD1	0	0	0 40.00
41.00		LC2	0	0	0 41.00
42.00		LC1	0	0	0 42.00
43.00		LB2	0	0	0 43.00
44.00		LB1	0	0	0 44.00
45.00		CE2	0	0	0 45.00
46.00		CE1	0	0	0 46.00
47.00		CD2	0	0	0 47.00
48.00		CD1	0	0	0 48.00
49.00		CC2	0	0	0 49.00
50.00		CC1	0	0	0 50.00
51.00		CB2	0	0	0 51.00
52.00		CB1	0	0	0 52.00
53.00		CA2	0	0	0 53.00
54.00		CA1	0	0	0 54.00
55.00		SE3	0	0	0 55.00
56.00		SE2	0	0	0 56.00
57.00		SE1	0	0	0 57.00
58.00		SSC	0	0	0 58.00
59.00		SSB	0	0	0 59.00
60.00		SSA	0	0	0 60.00
61.00		IB2	0	0	0 61.00
62.00		IB1	0	0	0 62.00
63.00		IA2	0	0	0 63.00
64.00		IA1	0	0	0 64.00
65.00		BB2	0	0	0 65.00
66.00		BB1	0	0	0 66.00
67.00		BA2	0	0	0 67.00
68.00		BA1	0	0	0 68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018

Worksheet S-7

Date/Time Prepared:
2/27/2019 1:34 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	15	15	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
SNF SERVICES						
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).			99914	99914	201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing		0	0.00		202.00
203.00	Recruitment		0	0.00		203.00
204.00	Retention of employees		0	0.00		204.00
205.00	Training		0	0.00		205.00
206.00	OTHER (SPECIFY)		0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		0			207.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 14-0143

Period:

Worksheet S-9

Hospice CCN: 14-1595

From 10/01/2017
To 09/30/2018PARTS I THROUGH IV
Date/Time Prepared:
2/27/2019 1:34 pm

		Hospice I					
		Unduplicated Days					
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)
		1.00	2.00	3.00	4.00	5.00	6.00
PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
1.00	Hospice Continuous Home Care						1.00
2.00	Hospice Routine Home Care						2.00
3.00	Hospice Inpatient Respite Care						3.00
4.00	Hospice General Inpatient Care						4.00
5.00	Total Hospice Days						5.00
Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
6.00	Number of patients receiving hospice care						6.00
7.00	Total number of unduplicated Continuous Care hours billable to Medicare						7.00
8.00	Average Length of Stay (line 5 / line 6)						8.00
9.00	Unduplicated census count						9.00

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	7,735	0	0	7,735	11.00
12.00	Hospice Inpatient Respite Care	1	0	0	1	12.00
13.00	Hospice General Inpatient Care	128	0	0	128	13.00
14.00	Total Hospice Days	7,864	0	0	7,864	14.00
PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0143	Period: From 10/01/2017 To 09/30/2018	Worksheet S-10 Date/Time Prepared: 2/27/2019 1:34 pm
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.324964 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	2,392,287		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?	Y		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0		5.00
6.00	Medicaid charges	31,295,348		6.00
7.00	Medicaid cost (line 1 times line 6)	10,169,861		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)	7,777,574		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP	0		9.00
10.00	Stand-alone CHIP charges	0		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0		12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0		16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care	0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	2,500		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	7,777,574		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)	590,720	2,067,604	2,658,324 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	191,963	2,067,604	2,259,567 21.00
22.00	Payments received from patients for amounts previously written off as charity care	100,125	325,845	425,970 22.00
23.00	Cost of charity care (line 21 minus line 22)	91,838	1,741,759	1,833,597 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)	2,948,477		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	265,453		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	408,389		27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,540,088		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	968,373		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,801,970		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	10,579,544		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018

Worksheet A

Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		3,256,709	3,256,709	-385,819	2,870,890	1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT		101,788	101,788	0	101,788	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2,959,260	2,959,260	123,988	3,083,248	2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	223,382	7,486,895	7,710,277	0	7,710,277	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,118,758	7,997,982	11,116,740	-169,340	10,947,400	5.00
7.00	00700	OPERATION OF PLANT	570,605	1,555,264	2,125,869	0	2,125,869	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	167,812	167,812	39,672	207,484	8.00
9.00	00900	HOUSEKEEPING	554,158	302,563	856,721	-39,672	817,049	9.00
10.00	01000	DIETARY	828,553	416,416	1,244,969	-932,595	312,374	10.00
11.00	01100	CAFETERIA	0	0	0	932,595	932,595	11.00
13.00	01300	NURSING ADMINISTRATION	1,140,694	92,710	1,233,404	0	1,233,404	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,460,524	448,704	1,909,228	0	1,909,228	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,997,526	1,596,136	4,593,662	-98,456	4,495,206	30.00
31.00	03100	INTENSIVE CARE UNIT	755,626	107,928	863,554	0	863,554	31.00
43.00	04300	NURSERY	55,506	155,095	210,601	0	210,601	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,122,959	4,560,972	6,683,931	0	6,683,931	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	267,935	70,889	338,824	98,456	437,280	52.00
53.00	05300	ANESTHESIOLOGY	0	1,947,553	1,947,553	0	1,947,553	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	870,016	1,247,462	2,117,478	0	2,117,478	54.00
54.01	05402	NUCLEAR MEDICINE	130,042	431,013	561,055	0	561,055	54.01
57.00	05700	CT SCAN	142,148	247,930	390,078	0	390,078	57.00
60.00	06000	LABORATORY	1,014,897	2,006,514	3,021,411	0	3,021,411	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	211,462	211,462	0	211,462	63.00
65.00	06500	RESPIRATORY THERAPY	411,996	84,268	496,264	0	496,264	65.00
66.00	06600	PHYSICAL THERAPY	1,337,178	136,087	1,473,265	0	1,473,265	66.00
67.00	06700	OCCUPATIONAL THERAPY	153,919	4,902	158,821	0	158,821	67.00
68.00	06800	SPEECH PATHOLOGY	80,629	2,535	83,164	0	83,164	68.00
69.00	06900	ELECTROCARDIOLOGY	93,593	135,180	228,773	0	228,773	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	46,577	78,742	125,319	0	125,319	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	26,300	249,753	276,053	8,081	284,134	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,318,082	2,318,082	0	2,318,082	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	785,031	1,851,673	2,636,704	-8,081	2,628,623	73.00
76.00	03020	SONOGRAPHY	187,205	365,241	552,446	0	552,446	76.00
76.01	03040	AUDIOLOGY	0	0	0	201,508	201,508	76.01
76.02	03160	CARDIAC REHAB	181,173	18,585	199,758	0	199,758	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	15,739,166	3,995,862	19,735,028	1,016,406	20,751,434	90.00
91.00	09100	EMERGENCY	998,706	2,244,661	3,243,367	0	3,243,367	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	855,919	855,919	0	855,919	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		965,103	965,103	-965,103	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
116.00	11600	HOSPICE	557,301	788,242	1,345,543	0	1,345,543	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,852,103	51,463,892	88,315,995	-178,360	88,137,635	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	0	0	194.00
194.01	07951	CONGREGATE LIVING	34,285	3,913	38,198	0	38,198	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	50,378	19,027	69,405	0	69,405	194.03
194.04	07954	RENTAL AREA/PPOS	0	0	0	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	2,052	2,052	0	2,052	194.05
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	252,949	424,006	676,955	0	676,955	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018

Worksheet A

Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20	07970	PARATRANSIT	0	0	0	178,360	178,360	194.20
194.21	07971	OCCUPATIONAL HEALTH	207,948	29,548	237,496	0	237,496	194.21
194.24	07974	SURGICAL ASSOCIATES	0	430	430	0	430	194.24
194.27	07977	MIDTOWN	0	0	0	0	0	194.27
194.28	07978	PAIN CLINIC	129,185	41,226	170,411	0	170,411	194.28
194.30	07980	WHC-PTON	0	0	0	0	0	194.30
194.31	07981	CFH	0	0	0	0	0	194.31
194.32	07982	PFS	0	0	0	0	0	194.32
200.00		TOTAL (SUM OF LINES 118 through 199)	37,526,848	51,984,094	89,510,942	0	89,510,942	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018

Worksheet A

Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-179,381	2,691,509	1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT	0	101,788	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,273	3,084,521	2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP	92	92	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,345,290	6,364,987	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-412,239	10,535,161	5.00
7.00	00700	OPERATION OF PLANT	-1,800	2,124,069	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	207,484	8.00
9.00	00900	HOUSEKEEPING	0	817,049	9.00
10.00	01000	DIETARY	0	312,374	10.00
11.00	01100	CAFETERIA	-229,903	702,692	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,233,404	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,680	1,907,548	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-924,918	3,570,288	30.00
31.00	03100	INTENSIVE CARE UNIT	-6,300	857,254	31.00
43.00	04300	NURSERY	-130,357	80,244	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	6,683,931	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	437,280	52.00
53.00	05300	ANESTHESIOLOGY	-1,730,666	216,887	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,117,478	54.00
54.01	05402	NUCLEAR MEDICINE	0	561,055	54.01
57.00	05700	CT SCAN	0	390,078	57.00
60.00	06000	LABORATORY	0	3,021,411	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	211,462	63.00
65.00	06500	RESPIRATORY THERAPY	0	496,264	65.00
66.00	06600	PHYSICAL THERAPY	-1,056	1,472,209	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	158,821	67.00
68.00	06800	SPEECH PATHOLOGY	0	83,164	68.00
69.00	06900	ELECTROCARDIOLOGY	-20,800	207,973	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	125,319	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	284,134	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,318,082	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-244,614	2,384,009	73.00
76.00	03020	SONOGRAPHY	0	552,446	76.00
76.01	03040	AUDIOLOGY	0	201,508	76.01
76.02	03160	CARDIAC REHAB	0	199,758	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	-8,521,850	12,229,584	90.00
91.00	09100	EMERGENCY	-1,505,451	1,737,916	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	855,919	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	114.00
116.00	11600	HOSPICE	0	1,345,543	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-15,254,940	72,882,695	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0	194.00
194.01	07951	CONGREGATE LIVING	0	38,198	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	194.02
194.03	07953	MANAGED CARE	0	69,405	194.03
194.04	07954	RENTAL AREA/PPOS	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	2,052	194.05
194.08	07958	ENT	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	676,955	194.09
194.10	07960	PERU MALL	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	194.13
194.14	07964	HENRY	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	194.16
194.17	07967	OGLESBY MP OB	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	194.19
194.20	07970	PARATRANSIT	0	178,360	194.20

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018

Worksheet A

Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
194.21	07971	OCCUPATIONAL HEALTH	0	237,496	194.21
194.24	07974	SURGICAL ASSOCIATES	0	430	194.24
194.27	07977	MIDTOWN	0	0	194.27
194.28	07978	PAIN CLINIC	0	170,411	194.28
194.30	07980	WHC-PTON	0	0	194.30
194.31	07981	CFH	0	0	194.31
194.32	07982	PFS	0	0	194.32
200.00		TOTAL (SUM OF LINES 118 through 199)	-15,254,940	74,256,002	200.00

RECLASSIFICATIONS

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018

Worksheet A-6

Date/Time Prepared:
2/27/2019 1:34 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
1.00	A - IV COSTS FROM PHARMACY				1.00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	8,081	
	TOTALS		0	8,081	
1.00	B - DIETARY RECLASS				1.00
	CAFETERIA	11.00	620,669	311,926	
	TOTALS		620,669	311,926	
1.00	C - LAUNDRY SALARIES				1.00
	LAUNDRY & LINEN SERVICE	8.00	39,672	0	
	TOTALS		39,672	0	
1.00 2.00 3.00	D - DEPRECIATION FOR OFF CAMPUS CLINICS				1.00 2.00 3.00
	CLINIC	90.00	0	1,217,914	
		0.00	0	0	
		0.00	0	0	
	TOTALS		0	1,217,914	
1.00	E - AUDIOLOGY COSTS				1.00
	AUDIOLOGY	76.01	0	201,508	
	TOTALS		0	201,508	
1.00 2.00 3.00	F - INTEREST EXPENSE ON EQUIPMENT				1.00 2.00 3.00
	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	123,988	
	ADMINISTRATIVE & GENERAL	5.00	0	9,020	
	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	832,095	
	TOTALS		0	965,103	
1.00	G - PARATRANSIT COSTS				1.00
	PARATRANSIT	194.20	130,951	47,409	
	TOTALS		130,951	47,409	
1.00	H - LABOR AND DELIVERY SALARIES				1.00
	DELIVERY ROOM & LABOR ROOM	52.00	98,456	0	
	TOTALS		98,456	0	
1.00	I - TO RECLASS EMPLOYED HOSPITALIST				1.00
	ADULTS & PEDIATRICS	30.00	766,175	0	
	TOTALS		766,175	0	
500.00	Grand Total: Increases		1,655,923	2,751,941	500.00

RECLASSIFICATIONS

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018

Worksheet A-6

Date/Time Prepared:
2/27/2019 1:34 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - IV COSTS FROM PHARMACY						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	8,081	0		1.00
	TOTALS		0	8,081			
	B - DIETARY RECLASS						
1.00	DIETARY	10.00	620,669	311,926	0		1.00
	TOTALS		620,669	311,926			
	C - LAUNDRY SALARIES						
1.00	HOUSEKEEPING	9.00	39,672	0	0		1.00
	TOTALS		39,672	0			
	D - DEPRECIATION FOR OFF CAMPUS CLINICS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,217,914	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	9		3.00
	TOTALS		0	1,217,914			
	E - AUDIOLOGY COSTS						
1.00	CLINIC	90.00	0	201,508	0		1.00
	TOTALS		0	201,508			
	F - INTEREST EXPENSE ON EQUIPMENT						
1.00	INTEREST EXPENSE	113.00	0	965,103	11		1.00
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	11		3.00
	TOTALS		0	965,103			
	G - PARATRANSIT COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	130,951	47,409	0		1.00
	TOTALS		130,951	47,409			
	H - LABOR AND DELIVERY SALARIES						
1.00	ADULTS & PEDIATRICS	30.00	98,456	0	0		1.00
	TOTALS		98,456	0			
	I - TO RECLASS EMPLOYED HOSPITALIST						
1.00	ADULTS & PEDIATRICS	30.00	0	766,175	0		1.00
	TOTALS		0	766,175			
500.00	Grand Total: Decreases		889,748	3,518,116			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet A-7
Part I
Date/Time Prepared:
2/27/2019 1:34 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	2,691,261	150,296	0	150,296	0	1.00	
2.00	Land Improvements	2,938,993	278,405	0	278,405	0	2.00	
3.00	Buildings and Fixtures	68,996,717	2,842,610	0	2,842,610	465,178	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	29,679,755	3,962,062	0	3,962,062	1,686,333	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	104,306,726	7,233,373	0	7,233,373	2,151,511	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	104,306,726	7,233,373	0	7,233,373	2,151,511	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	2,841,557	0					1.00
2.00	Land Improvements	3,217,398	0					2.00
3.00	Buildings and Fixtures	71,374,149	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	31,955,484	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	109,388,588	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	109,388,588	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet A-7
Part II
Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	3,256,709	0	0	0	0	1.00
1.01	OLD CAP REL COSTS-BLDG & FIXT	101,788	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2,959,260	0	0	0	0	2.00
2.01	OLD CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	6,317,757	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	3,256,709				1.00
1.01	OLD CAP REL COSTS-BLDG & FIXT	0	101,788				1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	2,959,260				2.00
2.01	OLD CAP REL COSTS-MVBLE EQUIP	0	0				2.01
3.00	Total (sum of lines 1-2)	0	6,317,757				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet A-7
Part III
Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
		1.00	2.00	3.00	4.00	5.00		
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	76,349,809	0	76,349,809	0.697968	0	1.00	
1.01	OLD CAP REL COSTS-BLDG & FIXT	1,083,295	0	1,083,295	0.009903	0	1.01	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	31,944,805	0	31,944,805	0.292031	0	2.00	
2.01	OLD CAP REL COSTS-MVBLE EQUIP	10,679	0	10,679	0.000098	0	2.01	
3.00	Total (sum of lines 1-2)	109,388,588	0	109,388,588	1.000000	0	3.00	
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
		6.00	7.00	8.00	9.00	10.00		
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	2,038,795	0	1.00	
1.01	OLD CAP REL COSTS-BLDG & FIXT	0	0	0	101,788	0	1.01	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	2,960,533	0	2.00	
2.01	OLD CAP REL COSTS-MVBLE EQUIP	0	0	0	92	0	2.01	
3.00	Total (sum of lines 1-2)	0	0	0	5,101,208	0	3.00	
Cost Center Description		SUMMARY OF CAPITAL						
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
		11.00	12.00	13.00	14.00	15.00		
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	652,714	0	0	0	2,691,509	1.00	
1.01	OLD CAP REL COSTS-BLDG & FIXT	0	0	0	0	101,788	1.01	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	123,988	0	0	0	3,084,521	2.00	
2.01	OLD CAP REL COSTS-MVBLE EQUIP	0	0	0	0	92	2.01	
3.00	Total (sum of lines 1-2)	776,702	0	0	0	5,877,910	3.00	

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018

Worksheet A-8

Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00		B	-179,381	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - OLD CAP REL COSTS-BLDG & FIXT (chapter 2)		0	OLD CAP REL COSTS-BLDG & FIXT	1.01	0	1.01
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - OLD CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	OLD CAP REL COSTS-MVBLE EQUIP	2.01	0	2.01
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-9,196	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-1,800	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-13,020,254			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	-12,343			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-229,903	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	-244,614	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,680	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	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	UTILIZATION REVIEW-SNF	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - OLD CAP REL COSTS-BLDG & FIXT		0	OLD CAP REL COSTS-BLDG & FIXT	1.01	0	26.01
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - OLD CAP REL COSTS-MVBLE EQUIP		0	OLD CAP REL COSTS-MVBLE EQUIP	2.01	0	27.01
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018

Worksheet A-8

Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
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	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.00
33.01	OUTSIDE PHYSICAL THERAPY	B	-1,056	PHYSICAL THERAPY	66.00	0	33.01
33.03	OB COMMISSIONS	B	-22	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.04
33.06	PATIENT PHONES	A	-26,278	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	PATIENT PHONES DEPRECIATION	A	-9,360	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	33.07
33.10	MISC INCOME	B	-1,135	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	PHYSICIAN RECRUITMENT	A	-322,150	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	EMPLOYEE HEALTH	A	-1,054,168	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.13
33.15	ADMIN COSTS FOR POB	A	750	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.16
33.17	LOBBYING PORTION OF IHHA DUES	A	-31,140	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.18
34.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	34.00
35.00	HOSPITALIST RECEPTIONIST & OTHER EXP	A	-111,210	ADULTS & PEDIATRICS	30.00	0	35.00
36.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	36.00
37.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	37.00
38.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	38.00
39.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	39.00
40.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	40.00
41.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	41.00
42.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	42.00
43.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	43.00
44.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	44.00
45.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-15,254,940				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018

Worksheet A-8-1

Date/Time Prepared:
2/27/2019 1:34 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	1,477,152	1,496,220 1.00
2.00		5.00	ADMINISTRATIVE & GENERAL	SISTERS SALARIES	0	4,000 2.00
3.00		2.01	OLD CAP REL COSTS-MVBLE EQUI	OLD CAPITAL COSTS	92	0 3.00
4.00		2.00	NEW CAP REL COSTS-MVBLE EQUI	NEW CAPITAL COSTS	10,633	0 4.00
5.00	0			0	1,487,877	1,500,220 5.00

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

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	B		0.00	SRS OF MARY OF THE PRES	100.00	6.00
7.00	G	SMP HEALTH CORP	0.00	SMP HEALTH CORP	0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	NON-FINANCIAL				100.00

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

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

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

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018

Worksheet A-8-1

Date/Time Prepared:
2/27/2019 1:34 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-19,068	0		1.00
2.00	-4,000	0		2.00
3.00	92	9		3.00
4.00	10,633	9		4.00
5.00	-12,343			5.00

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

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

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

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

6.00	RELIGIOUS COMMUNITY		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018

Worksheet A-8-2

Date/Time Prepared:
2/27/2019 1:34 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	53.00	ANESTHESIOLOGY	1,766,000	1,505,331	260,669	239,400	307	1.00
2.00	91.00	EMERGENCY	1,810,181	1,078,506	731,675	179,000	3,541	2.00
3.00	43.00	NURSERY	130,357	130,357	0	0	0	3.00
4.00	60.00	LABORATORY	35,000	0	35,000	260,300	520	4.00
5.00	69.00	ELECTROCARDIOLOGY	20,800	20,800	0	0	0	5.00
6.00	31.00	INTENSIVE CARE UNIT	6,300	6,300	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	766,175	757,725	8,450	211,500	54	7.00
8.00	30.00	ADULTS & PEDIATRICS	107,831	0	107,831	211,500	539	8.00
9.00	90.00	CLINIC	8,289,480	8,289,480	0	0	0	9.00
10.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	291,122	291,122	0	0	0	10.00
11.00	90.00	CLINIC	29,970	29,970	0	0	0	11.00
12.00	16.00	MEDICAL RECORDS & LIBRARY	7,500	0	7,500	211,500	125	12.00
13.00	90.00	CLINIC	202,400	202,400	0	0	0	13.00
200.00			13,463,116	12,311,991	1,151,125		5,086	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	53.00	ANESTHESIOLOGY	35,334	1,767	0	0	0	1.00
2.00	91.00	EMERGENCY	304,730	15,237	0	0	0	2.00
3.00	43.00	NURSERY	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	65,075	3,254	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	5,491	275	0	0	0	7.00
8.00	30.00	ADULTS & PEDIATRICS	54,807	2,740	0	0	0	8.00
9.00	90.00	CLINIC	0	0	0	0	0	9.00
10.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	10.00
11.00	90.00	CLINIC	0	0	0	0	0	11.00
12.00	16.00	MEDICAL RECORDS & LIBRARY	12,710	636	0	0	0	12.00
13.00	90.00	CLINIC	0	0	0	0	0	13.00
200.00			478,147	23,909	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	53.00	ANESTHESIOLOGY	0	35,334	225,335	1,730,666		1.00
2.00	91.00	EMERGENCY	0	304,730	426,945	1,505,451		2.00
3.00	43.00	NURSERY	0	0	0	130,357		3.00
4.00	60.00	LABORATORY	0	65,075	0	0		4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	20,800		5.00
6.00	31.00	INTENSIVE CARE UNIT	0	0	0	6,300		6.00
7.00	30.00	ADULTS & PEDIATRICS	0	5,491	2,959	760,684		7.00
8.00	30.00	ADULTS & PEDIATRICS	0	54,807	53,024	53,024		8.00
9.00	90.00	CLINIC	0	0	0	8,289,480		9.00
10.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	291,122		10.00
11.00	90.00	CLINIC	0	0	0	29,970		11.00
12.00	16.00	MEDICAL RECORDS & LIBRARY	0	12,710	0	0		12.00
13.00	90.00	CLINIC	0	0	0	202,400		13.00
200.00			0	478,147	708,263	13,020,254		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet B
Part I
Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Description			CAPITAL RELATED COSTS					
			Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	OLD BLDG & FIXT	NEW MVBLE EQUIP		OLD MVBLE EQUIP
			0	1.00	1.01	2.00	2.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,691,509	2,691,509				1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT	101,788	0	101,788			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	3,084,521			3,084,521		2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP	92			0	92	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,364,987	9,397	355	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,535,161	951,823	35,997	921,798	92	5.00
7.00	00700	OPERATION OF PLANT	2,124,069	254,914	9,640	12,715	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	207,484	6,746	255	0	0	8.00
9.00	00900	HOUSEKEEPING	817,049	26,925	1,018	13,809	0	9.00
10.00	01000	DIETARY	312,374	66,968	2,533	21,665	0	10.00
11.00	01100	CAFETERIA	702,692	23,025	871	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,233,404	23,110	874	4,159	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,907,548	35,642	1,348	20,340	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,570,288	198,202	7,496	143,319	0	30.00
31.00	03100	INTENSIVE CARE UNIT	857,254	43,289	1,637	26,434	0	31.00
43.00	04300	NURSERY	80,244	10,374	392	35,303	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,683,931	233,470	8,829	397,957	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	437,280	5,225	198	17,986	0	52.00
53.00	05300	ANESTHESIOLOGY	216,887	3,917	148	8,784	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,117,478	68,098	2,575	526,391	0	54.00
54.01	05402	NUCLEAR MEDICINE	561,055	17,825	674	91,258	0	54.01
57.00	05700	CT SCAN	390,078	5,523	209	157,159	0	57.00
60.00	06000	LABORATORY	3,021,411	33,212	1,256	47,787	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	211,462	1,988	75	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	496,264	13,254	501	22,102	0	65.00
66.00	06600	PHYSICAL THERAPY	1,472,209	88,846	3,360	2,555	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	158,821	331	13	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	83,164	1,495	57	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	207,973	1,122	42	13,987	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	125,319	11,317	428	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	284,134	62,839	2,376	21,329	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,318,082	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,384,009	24,299	919	26,392	0	73.00
76.00	03020	SONOGRAPHY	552,446	4,546	172	48,593	0	76.00
76.01	03040	AUDIOLOGY	201,508	0	0	0	0	76.01
76.02	03160	CARDIAC REHAB	199,758	12,668	479	8,338	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	12,229,584	144,097	5,450	359,741	0	90.00
91.00	09100	EMERGENCY	1,737,916	83,289	3,150	124,742	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	855,919	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	1,345,543	8,275	313	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	72,882,695	2,476,051	93,640	3,074,643	92	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,343	429	0	0	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	0	0	194.00
194.01	07951	CONGREGATE LIVING	38,198	112,780	4,265	0	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	69,405	0	0	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	0	66,696	2,522	0	0	194.04
194.05	07955	SPECIALTY CLINICS	2,052	0	0	1,635	0	194.05
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	676,955	24,639	932	4,554	0	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	OLD BLDG & FIXT	NEW MVBLE EQUIP	OLD MVBLE EQUIP	
			0	1.00	1.01	2.00	2.01	
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20	07970	PARATRANSIT	178,360	0	0	0	0	194.20
194.21	07971	OCCUPATIONAL HEALTH	237,496	0	0	0	0	194.21
194.24	07974	SURGICAL ASSOCIATES	430	0	0	0	0	194.24
194.27	07977	MIDTOWN	0	0	0	3,689	0	194.27
194.28	07978	PAIN CLINIC	170,411	0	0	0	0	194.28
194.30	07980	WHC-PTON	0	0	0	0	0	194.30
194.31	07981	CFH	0	0	0	0	0	194.31
194.32	07982	PFS	0	0	0	0	0	194.32
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	74,256,002	2,691,509	101,788	3,084,521	92	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet B
Part I
Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4.00	4A	5.00	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,374,739					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	682,262	13,127,133	13,127,133			5.00
7.00	00700	OPERATION OF PLANT	122,590	2,523,928	542,001	3,065,929		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,523	223,008	47,890	14,019	284,917	8.00
9.00	00900	HOUSEKEEPING	110,534	969,335	208,160	55,952	0	9.00
10.00	01000	DIETARY	44,662	448,202	96,249	139,164	0	10.00
11.00	01100	CAFETERIA	133,346	859,934	184,667	47,847	0	11.00
13.00	01300	NURSING ADMINISTRATION	245,070	1,506,617	323,538	48,024	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	313,783	2,278,661	489,331	74,066	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	764,122	4,683,427	1,005,743	411,877	185,291	30.00
31.00	03100	INTENSIVE CARE UNIT	162,341	1,090,955	234,277	89,957	15,186	31.00
43.00	04300	NURSERY	11,925	138,238	29,686	21,558	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	456,103	7,780,290	1,670,778	485,166	30,201	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	78,717	539,406	115,835	10,858	0	52.00
53.00	05300	ANESTHESIOLOGY	0	229,736	49,335	8,139	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	186,917	2,901,459	623,074	141,512	19,004	54.00
54.01	05402	NUCLEAR MEDICINE	27,939	698,751	150,053	37,042	0	54.01
57.00	05700	CT SCAN	30,540	583,509	125,306	11,476	3,789	57.00
60.00	06000	LABORATORY	218,044	3,321,710	713,321	69,017	142	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	213,525	45,853	4,131	0	63.00
65.00	06500	RESPIRATORY THERAPY	88,514	620,635	133,278	27,543	556	65.00
66.00	06600	PHYSICAL THERAPY	287,283	1,854,253	398,192	184,628	15,186	66.00
67.00	06700	OCCUPATIONAL THERAPY	33,068	192,233	41,281	689	0	67.00
68.00	06800	SPEECH PATHOLOGY	17,323	102,039	21,912	3,107	0	68.00
69.00	06900	ELECTROCARDIOLOGY	20,108	243,232	52,233	2,331	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	10,007	147,071	31,583	23,518	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,650	376,328	80,815	130,583	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,318,082	497,797	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	168,658	2,604,277	559,255	50,496	0	73.00
76.00	03020	SONOGRAPHY	40,220	645,977	138,720	9,446	0	76.00
76.01	03040	AUDIOLOGY	0	201,508	43,273	0	0	76.01
76.02	03160	CARDIAC REHAB	38,924	260,167	55,870	26,325	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	1,560,172	14,299,044	3,070,660	299,444	0	90.00
91.00	09100	EMERGENCY	214,565	2,163,662	464,636	173,081	15,186	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	855,919	183,804	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
116.00	11600	HOSPICE	119,732	1,473,863	316,505	17,197	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,201,642	72,476,114	12,744,911	2,618,193	284,541	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,772	2,528	23,571	0	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	0	0	194.00
194.01	07951	CONGREGATE LIVING	7,366	162,609	34,919	234,364	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	10,823	80,228	17,229	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	0	69,218	14,864	138,599	0	194.04
194.05	07955	SPECIALTY CLINICS	0	3,687	792	0	376	194.05
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	54,344	761,424	163,512	51,202	0	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20	07970	PARATRANSIT	28,134	206,494	44,344	0	0	194.20

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:
From 10/01/2017
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Cost Center Description		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		4.00	4A	5.00	7.00	8.00	
194.21	07971	OCCUPATIONAL HEALTH	44,676	282,172	60,595	0	0 194.21
194.24	07974	SURGICAL ASSOCIATES	0	430	92	0	0 194.24
194.27	07977	MIDTOWN	0	3,689	792	0	0 194.27
194.28	07978	PAIN CLINIC	27,754	198,165	42,555	0	0 194.28
194.30	07980	WHC-PTON	0	0	0	0	0 194.30
194.31	07981	CFH	0	0	0	0	0 194.31
194.32	07982	PFS	0	0	0	0	0 194.32
200.00		Cross Foot Adjustments		0			200.00
201.00		Negative Cost Centers	0	0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	6,374,739	74,256,002	13,127,133	3,065,929	284,917 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet B
Part I
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Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	1,233,447					9.00
10.00	01000	DIETARY	61,256	744,871				10.00
11.00	01100	CAFETERIA	48,849	0	1,141,297			11.00
13.00	01300	NURSING ADMINISTRATION	36,712	0	49,575	1,964,466		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	74,235	0	139,104	0	3,055,397	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	471,364	492,283	235,504	857,002	162,220	30.00
31.00	03100	INTENSIVE CARE UNIT	60,716	94,033	48,688	177,170	22,195	31.00
43.00	04300	NURSERY	5,588	0	7,317	26,639	9,207	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	98,208	31	157,062	571,485	457,658	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	24,635	0	22,925	83,345	15,241	52.00
53.00	05300	ANESTHESIOLOGY	991	0	0	0	85,790	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	36,501	0	70,594	0	208,097	54.00
54.01	05402	NUCLEAR MEDICINE	2,193	0	9,711	0	38,567	54.01
57.00	05700	CT SCAN	2,193	0	6,430	0	220,951	57.00
60.00	06000	LABORATORY	24,605	0	90,238	0	480,827	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,584	0	0	0	5,335	63.00
65.00	06500	RESPIRATORY THERAPY	5,948	0	30,730	0	46,274	65.00
66.00	06600	PHYSICAL THERAPY	12,227	0	0	0	127,417	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	12,866	67.00
68.00	06800	SPEECH PATHOLOGY	2,193	0	0	0	5,611	68.00
69.00	06900	ELECTROCARDIOLOGY	3,815	0	6,917	0	67,394	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	871	0	4,612	0	17,199	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,948	0	5,099	0	145,124	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	54,546	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,605	0	41,505	0	92,892	73.00
76.00	03020	SONOGRAPHY	2,193	0	10,820	0	96,753	76.00
76.01	03040	AUDIOLOGY	2,193	0	0	0	5,606	76.01
76.02	03160	CARDIAC REHAB	0	0	0	0	14,115	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	80,793	0	94,636	90.00
91.00	09100	EMERGENCY	24,605	0	68,377	248,825	131,378	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	10,592	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	38,091	0	53,578	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,035,228	586,347	1,124,092	1,964,466	2,682,069	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,193	0	0	0	0	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	0	97,918	194.00
194.01	07951	CONGREGATE LIVING	0	158,524	3,725	0	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	44,065	194.02
194.03	07953	MANAGED CARE	0	0	2,838	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	196,026	0	0	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	0	0	0	6,029	194.05
194.08	07958	ENT	0	0	0	0	23,143	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	0	0	0	8,544	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	42,557	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	39,686	194.13
194.14	07964	HENRY	0	0	0	0	1,612	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	1,391	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	1,983	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	31,900	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	5,142	194.19
194.20	07970	PARATRANSIT	0	0	0	0	0	194.20

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet B
Part I
Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
		9.00	10.00	11.00	13.00	16.00	
194.21	07971 OCCUPATIONAL HEALTH	0	0	10,642	0	5,394	194.21
194.24	07974 SURGICAL ASSOCIATES	0	0	0	0	0	194.24
194.27	07977 MIDTOWN	0	0	0	0	41,812	194.27
194.28	07978 PAIN CLINIC	0	0	0	0	1,346	194.28
194.30	07980 WHC-PTON	0	0	0	0	0	194.30
194.31	07981 CFH	0	0	0	0	20,806	194.31
194.32	07982 PFS	0	0	0	0	0	194.32
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)	1,233,447	744,871	1,141,297	1,964,466	3,055,397	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet B
Part I
Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	0				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	8,504,711	0	8,504,711	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,833,177	0	1,833,177	31.00
43.00	04300	NURSERY	0	238,233	0	238,233	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	11,250,879	0	11,250,879	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	812,245	0	812,245	52.00
53.00	05300	ANESTHESIOLOGY	0	373,991	0	373,991	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,000,241	0	4,000,241	54.00
54.01	05402	NUCLEAR MEDICINE	0	936,317	0	936,317	54.01
57.00	05700	CT SCAN	0	953,654	0	953,654	57.00
60.00	06000	LABORATORY	0	4,699,860	0	4,699,860	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	271,428	0	271,428	63.00
65.00	06500	RESPIRATORY THERAPY	0	864,964	0	864,964	65.00
66.00	06600	PHYSICAL THERAPY	0	2,591,903	0	2,591,903	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	247,069	0	247,069	67.00
68.00	06800	SPEECH PATHOLOGY	0	134,862	0	134,862	68.00
69.00	06900	ELECTROCARDIOLOGY	0	375,922	0	375,922	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	224,854	0	224,854	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	743,897	0	743,897	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,870,425	0	2,870,425	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,373,030	0	3,373,030	73.00
76.00	03020	SONOGRAPHY	0	903,909	0	903,909	76.00
76.01	03040	AUDIOLOGY	0	252,580	0	252,580	76.01
76.02	03160	CARDIAC REHAB	0	356,477	0	356,477	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	0	17,844,577	0	17,844,577	90.00
91.00	09100	EMERGENCY	0	3,289,750	0	3,289,750	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	1,050,315	0	1,050,315	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	1,899,234	0	1,899,234	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	70,898,504	0	70,898,504	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	40,064	0	40,064	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	97,918	0	97,918	194.00
194.01	07951	CONGREGATE LIVING	0	594,141	0	594,141	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	44,065	0	44,065	194.02
194.03	07953	MANAGED CARE	0	100,295	0	100,295	194.03
194.04	07954	RENTAL AREA/PPOS	0	418,707	0	418,707	194.04
194.05	07955	SPECIALTY CLINICS	0	10,884	0	10,884	194.05
194.08	07958	ENT	0	23,143	0	23,143	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	984,682	0	984,682	194.09
194.10	07960	PERU MALL	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	42,557	0	42,557	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	39,686	0	39,686	194.13
194.14	07964	HENRY	0	1,612	0	1,612	194.14
194.16	07966	SPRING VALLEY CLINIC	0	1,391	0	1,391	194.16
194.17	07967	OGLESBY MP OB	0	1,983	0	1,983	194.17
194.18	07968	FAMILY HEALTH CENTER	0	31,900	0	31,900	194.18

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:
From 10/01/2017
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Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
194.19	07969	GRANVILLE CLINIC	0	5,142	0	5,142		194.19
194.20	07970	PARATRANSIT	0	250,838	0	250,838		194.20
194.21	07971	OCCUPATIONAL HEALTH	0	358,803	0	358,803		194.21
194.24	07974	SURGICAL ASSOCIATES	0	522	0	522		194.24
194.27	07977	MIDTOWN	0	46,293	0	46,293		194.27
194.28	07978	PAIN CLINIC	0	242,066	0	242,066		194.28
194.30	07980	WHC-PTON	0	0	0	0		194.30
194.31	07981	CFH	0	20,806	0	20,806		194.31
194.32	07982	PFS	0	0	0	0		194.32
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)	0	74,256,002	0	74,256,002		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet B
Part II
Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Description			CAPITAL RELATED COSTS					
			Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	OLD BLDG & FIXT	NEW MVBLE EQUIP		OLD MVBLE EQUIP
			0	1.00	1.01	2.00	2.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,397	355	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,082	951,823	35,997	921,798	92	5.00
7.00	00700	OPERATION OF PLANT	372	254,914	9,640	12,715	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,746	255	0	0	8.00
9.00	00900	HOUSEKEEPING	1,190	26,925	1,018	13,809	0	9.00
10.00	01000	DIETARY	0	66,968	2,533	21,665	0	10.00
11.00	01100	CAFETERIA	0	23,025	871	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	23,110	874	4,159	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	35,642	1,348	20,340	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	33,121	198,202	7,496	143,319	0	30.00
31.00	03100	INTENSIVE CARE UNIT	7,060	43,289	1,637	26,434	0	31.00
43.00	04300	NURSERY	0	10,374	392	35,303	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	161,760	233,470	8,829	397,957	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,225	198	17,986	0	52.00
53.00	05300	ANESTHESIOLOGY	29,260	3,917	148	8,784	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	109,771	68,098	2,575	526,391	0	54.00
54.01	05402	NUCLEAR MEDICINE	0	17,825	674	91,258	0	54.01
57.00	05700	CT SCAN	0	5,523	209	157,159	0	57.00
60.00	06000	LABORATORY	0	33,212	1,256	47,787	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,988	75	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	9,372	13,254	501	22,102	0	65.00
66.00	06600	PHYSICAL THERAPY	9,600	88,846	3,360	2,555	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	331	13	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,495	57	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,122	42	13,987	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	11,317	428	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,140	62,839	2,376	21,329	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	14,338	24,299	919	26,392	0	73.00
76.00	03020	SONOGRAPHY	0	4,546	172	48,593	0	76.00
76.01	03040	AUDIOLOGY	0	0	0	0	0	76.01
76.02	03160	CARDIAC REHAB	0	12,668	479	8,338	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	615	144,097	5,450	359,741	0	90.00
91.00	09100	EMERGENCY	9,952	83,289	3,150	124,742	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	49,244	8,275	313	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	449,877	2,476,051	93,640	3,074,643	92	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,343	429	0	0	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	0	0	194.00
194.01	07951	CONGREGATE LIVING	0	112,780	4,265	0	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	0	0	0	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	0	66,696	2,522	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	0	0	1,635	0	194.05
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	24,639	932	4,554	0	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	OLD BLDG & FIXT	NEW MVBLE EQUIP	OLD MVBLE EQUIP	
			0	1.00	1.01	2.00	2.01	
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20	07970	PARATRANSIT	0	0	0	0	0	194.20
194.21	07971	OCCUPATIONAL HEALTH	0	0	0	0	0	194.21
194.24	07974	SURGICAL ASSOCIATES	0	0	0	0	0	194.24
194.27	07977	MIDTOWN	0	0	0	3,689	0	194.27
194.28	07978	PAIN CLINIC	888	0	0	0	0	194.28
194.30	07980	WHC-PTON	0	0	0	0	0	194.30
194.31	07981	CFH	0	0	0	0	0	194.31
194.32	07982	PFS	0	0	0	0	0	194.32
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	450,765	2,691,509	101,788	3,084,521	92	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Period:
From 10/01/2017
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Date/Time Prepared:
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Cost Center Description			Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			2A	4.00	5.00	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,752	9,752				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,919,792	1,045	1,920,837			5.00
7.00	00700	OPERATION OF PLANT	277,641	188	79,309	357,138		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,001	13	7,008	1,633	15,655	8.00
9.00	00900	HOUSEKEEPING	42,942	169	30,459	6,518	0	9.00
10.00	01000	DIETARY	91,166	68	14,084	16,211	0	10.00
11.00	01100	CAFETERIA	23,896	204	27,022	5,574	0	11.00
13.00	01300	NURSING ADMINISTRATION	28,143	375	47,342	5,594	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	57,330	481	71,602	8,628	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	382,138	1,170	147,167	47,978	10,182	30.00
31.00	03100	INTENSIVE CARE UNIT	78,420	249	34,281	10,479	834	31.00
43.00	04300	NURSERY	46,069	18	4,344	2,511	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	802,016	698	244,480	56,516	1,659	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	23,409	121	16,950	1,265	0	52.00
53.00	05300	ANESTHESIOLOGY	42,109	0	7,219	948	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	706,835	286	91,173	16,484	1,044	54.00
54.01	05402	NUCLEAR MEDICINE	109,757	43	21,957	4,315	0	54.01
57.00	05700	CT SCAN	162,891	47	18,336	1,337	208	57.00
60.00	06000	LABORATORY	82,255	334	104,378	8,040	8	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,063	0	6,710	481	0	63.00
65.00	06500	RESPIRATORY THERAPY	45,229	136	19,502	3,208	31	65.00
66.00	06600	PHYSICAL THERAPY	104,361	440	58,266	21,507	834	66.00
67.00	06700	OCCUPATIONAL THERAPY	344	51	6,041	80	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,552	27	3,206	362	0	68.00
69.00	06900	ELECTROCARDIOLOGY	15,151	31	7,643	271	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	11,745	15	4,621	2,739	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	90,684	9	11,825	15,211	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72,841	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	65,948	258	81,834	5,882	0	73.00
76.00	03020	SONOGRAPHY	53,311	62	20,299	1,100	0	76.00
76.01	03040	AUDIOLOGY	0	0	6,332	0	0	76.01
76.02	03160	CARDIAC REHAB	21,485	60	8,175	3,066	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	509,903	2,377	449,302	34,881	0	90.00
91.00	09100	EMERGENCY	221,133	329	67,989	20,161	834	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	26,896	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	57,832	183	46,313	2,003	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,094,303	9,487	1,864,906	304,983	15,634	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,772	0	370	2,746	0	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	0	0	194.00
194.01	07951	CONGREGATE LIVING	117,045	11	5,110	27,300	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	0	17	2,521	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	69,218	0	2,175	16,145	0	194.04
194.05	07955	SPECIALTY CLINICS	1,635	0	116	0	21	194.05
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	30,125	83	23,926	5,964	0	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20	07970	PARATRANSIT	0	43	6,489	0	0	194.20

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ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet B
Part II
Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	80,088					9.00
10.00	01000	DIETARY	3,977	125,506				10.00
11.00	01100	CAFETERIA	3,172	0	59,868			11.00
13.00	01300	NURSING ADMINISTRATION	2,384	0	2,601	86,439		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,820	0	7,297	0	150,158	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	30,606	82,947	12,353	37,709	7,971	30.00
31.00	03100	INTENSIVE CARE UNIT	3,942	15,844	2,554	7,796	1,091	31.00
43.00	04300	NURSERY	363	0	384	1,172	452	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,377	5	8,239	25,146	22,488	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,600	0	1,203	3,667	749	52.00
53.00	05300	ANESTHESIOLOGY	64	0	0	0	4,216	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,370	0	3,703	0	10,225	54.00
54.01	05402	NUCLEAR MEDICINE	142	0	509	0	1,895	54.01
57.00	05700	CT SCAN	142	0	337	0	10,857	57.00
60.00	06000	LABORATORY	1,598	0	4,734	0	23,653	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	168	0	0	0	262	63.00
65.00	06500	RESPIRATORY THERAPY	386	0	1,612	0	2,274	65.00
66.00	06600	PHYSICAL THERAPY	794	0	0	0	6,261	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	632	67.00
68.00	06800	SPEECH PATHOLOGY	142	0	0	0	276	68.00
69.00	06900	ELECTROCARDIOLOGY	248	0	363	0	3,312	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	57	0	242	0	845	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	386	0	267	0	7,131	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,680	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,598	0	2,177	0	4,564	73.00
76.00	03020	SONOGRAPHY	142	0	568	0	4,754	76.00
76.01	03040	AUDIOLOGY	142	0	0	0	275	76.01
76.02	03160	CARDIAC REHAB	0	0	0	0	694	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	4,238	0	4,650	90.00
91.00	09100	EMERGENCY	1,598	0	3,587	10,949	6,456	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	520	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	1,998	0	2,633	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	67,218	98,796	58,966	86,439	131,816	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	142	0	0	0	0	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	0	4,811	194.00
194.01	07951	CONGREGATE LIVING	0	26,710	195	0	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	2,165	194.02
194.03	07953	MANAGED CARE	0	0	149	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	12,728	0	0	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	0	0	0	296	194.05
194.08	07958	ENT	0	0	0	0	1,137	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	0	0	0	420	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	2,091	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	1,950	194.13
194.14	07964	HENRY	0	0	0	0	79	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	68	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	97	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	1,567	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	253	194.19
194.20	07970	PARATRANSIT	0	0	0	0	0	194.20

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet B
Part II
Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
		9.00	10.00	11.00	13.00	16.00	
194.21	07971	0	0	558	0	265	194.21
194.24	07974	0	0	0	0	0	194.24
194.27	07977	0	0	0	0	2,055	194.27
194.28	07978	0	0	0	0	66	194.28
194.30	07980	0	0	0	0	0	194.30
194.31	07981	0	0	0	0	1,022	194.31
194.32	07982	0	0	0	0	0	194.32
200.00							200.00
201.00							201.00
202.00							202.00
Cross Foot Adjustments							
Negative Cost Centers							
TOTAL (sum lines 118 through 201)		80,088	125,506	59,868	86,439	150,158	

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet B
Part II
Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	0				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	760,221	0	760,221	30.00
31.00	03100	INTENSIVE CARE UNIT	0	155,490	0	155,490	31.00
43.00	04300	NURSERY	0	55,313	0	55,313	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,167,624	0	1,167,624	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	48,964	0	48,964	52.00
53.00	05300	ANESTHESIOLOGY	0	54,556	0	54,556	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	832,120	0	832,120	54.00
54.01	05402	NUCLEAR MEDICINE	0	138,618	0	138,618	54.01
57.00	05700	CT SCAN	0	194,155	0	194,155	57.00
60.00	06000	LABORATORY	0	225,000	0	225,000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	9,684	0	9,684	63.00
65.00	06500	RESPIRATORY THERAPY	0	72,378	0	72,378	65.00
66.00	06600	PHYSICAL THERAPY	0	192,463	0	192,463	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,148	0	7,148	67.00
68.00	06800	SPEECH PATHOLOGY	0	5,565	0	5,565	68.00
69.00	06900	ELECTROCARDIOLOGY	0	27,019	0	27,019	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	20,264	0	20,264	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	125,513	0	125,513	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	75,521	0	75,521	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	162,261	0	162,261	73.00
76.00	03020	SONOGRAPHY	0	80,236	0	80,236	76.00
76.01	03040	AUDIOLOGY	0	6,749	0	6,749	76.01
76.02	03160	CARDIAC REHAB	0	33,480	0	33,480	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	0	1,005,351	0	1,005,351	90.00
91.00	09100	EMERGENCY	0	333,036	0	333,036	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	27,416	0	27,416	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	110,962	0	110,962	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	5,927,107	0	5,927,107	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,030	0	15,030	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	4,811	0	4,811	194.00
194.01	07951	CONGREGATE LIVING	0	176,371	0	176,371	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	2,165	0	2,165	194.02
194.03	07953	MANAGED CARE	0	2,687	0	2,687	194.03
194.04	07954	RENTAL AREA/PPOS	0	100,266	0	100,266	194.04
194.05	07955	SPECIALTY CLINICS	0	2,068	0	2,068	194.05
194.08	07958	ENT	0	1,137	0	1,137	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	60,518	0	60,518	194.09
194.10	07960	PERU MALL	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	2,091	0	2,091	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	1,950	0	1,950	194.13
194.14	07964	HENRY	0	79	0	79	194.14
194.16	07966	SPRING VALLEY CLINIC	0	68	0	68	194.16
194.17	07967	OGLESBY MP OB	0	97	0	97	194.17
194.18	07968	FAMILY HEALTH CENTER	0	1,567	0	1,567	194.18

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
194.19	07969	GRANVILLE CLINIC	0	253	0	253		194.19
194.20	07970	PARATRANSIT	0	6,532	0	6,532		194.20
194.21	07971	OCCUPATIONAL HEALTH	0	9,758	0	9,758		194.21
194.24	07974	SURGICAL ASSOCIATES	0	14	0	14		194.24
194.27	07977	MIDTOWN	0	5,860	0	5,860		194.27
194.28	07978	PAIN CLINIC	0	7,224	0	7,224		194.28
194.30	07980	WHC-PTON	0	0	0	0		194.30
194.31	07981	CFH	0	1,022	0	1,022		194.31
194.32	07982	PFS	0	0	0	0		194.32
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	6,328,675	0	6,328,675		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018

Worksheet B-1

Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Description		CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)	
		NEW BLDG & FIXT (SQUARE FEET)	OLD BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	OLD MVBLE EQUIP (DOLLAR VALUE)		
		1.00	1.01	2.00	2.01	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	316,786				1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT	0	316,786			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2,959,260			2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP		0	95		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,106	1,106	0	29,671,569	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	112,028	112,028	884,365	95	5.00
7.00	00700	OPERATION OF PLANT	30,003	30,003	12,199	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	794	794	0	39,672	8.00
9.00	00900	HOUSEKEEPING	3,169	3,169	13,248	0	9.00
10.00	01000	DIETARY	7,882	7,882	20,785	0	10.00
11.00	01100	CAFETERIA	2,710	2,710	0	620,669	11.00
13.00	01300	NURSING ADMINISTRATION	2,720	2,720	3,990	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,195	4,195	19,514	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	23,328	23,328	137,499	0	30.00
31.00	03100	INTENSIVE CARE UNIT	5,095	5,095	25,361	0	31.00
43.00	04300	NURSERY	1,221	1,221	33,869	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	27,479	27,479	381,796	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	615	615	17,256	0	52.00
53.00	05300	ANESTHESIOLOGY	461	461	8,427	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,015	8,015	505,015	0	54.00
54.01	05402	NUCLEAR MEDICINE	2,098	2,098	87,552	0	54.01
57.00	05700	CT SCAN	650	650	150,777	0	57.00
60.00	06000	LABORATORY	3,909	3,909	45,846	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	234	234	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,560	1,560	21,204	0	65.00
66.00	06600	PHYSICAL THERAPY	10,457	10,457	2,451	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	39	39	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	176	176	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	132	132	13,419	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,332	1,332	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,396	7,396	20,463	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,860	2,860	25,320	0	73.00
76.00	03020	SONOGRAPHY	535	535	46,620	0	76.00
76.01	03040	AUDIOLOGY	0	0	0	0	76.01
76.02	03160	CARDIAC REHAB	1,491	1,491	7,999	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	16,960	16,960	345,132	0	90.00
91.00	09100	EMERGENCY	9,803	9,803	119,676	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	974	974	0	557,301	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	291,427	291,427	2,949,783	95	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,335	1,335	0	0	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	0	194.00
194.01	07951	CONGREGATE LIVING	13,274	13,274	0	34,285	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	194.02
194.03	07953	MANAGED CARE	0	0	0	50,378	194.03
194.04	07954	RENTAL AREA/PPOS	7,850	7,850	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	0	1,569	0	194.05
194.08	07958	ENT	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	2,900	2,900	4,369	0	194.09
194.10	07960	PERU MALL	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	194.16

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018

Worksheet B-1

Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Description		CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)	
		NEW BLDG & FIXT (SQUARE FEET)	OLD BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	OLD MVBLE EQUIP (DOLLAR VALUE)		
		1.00	1.01	2.00	2.01	4.00	
194.17	07967	0	0	0	0	0	194.17
194.18	07968	0	0	0	0	0	194.18
194.19	07969	0	0	0	0	0	194.19
194.20	07970	0	0	0	0	130,951	194.20
194.21	07971	0	0	0	0	207,948	194.21
194.24	07974	0	0	0	0	0	194.24
194.27	07977	0	0	3,539	0	0	194.27
194.28	07978	0	0	0	0	129,185	194.28
194.30	07980	0	0	0	0	0	194.30
194.31	07981	0	0	0	0	0	194.31
194.32	07982	0	0	0	0	0	194.32
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,691,509	101,788	3,084,521	92	6,374,739	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	8.496300	0.321315	1.042328	0.968421	0.214843	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)					9,752	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)					0.000329	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: 14-0143

Period:
From 10/01/2017
To 09/30/2018

Worksheet B-1

Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Description			Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
			5A	5.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-13,127,133	61,128,869				5.00
7.00	00700	OPERATION OF PLANT	0	2,523,928	173,649			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	223,008	794	268,498		8.00
9.00	00900	HOUSEKEEPING	0	969,335	3,169	0	41,057	9.00
10.00	01000	DIETARY	0	448,202	7,882	0	2,039	10.00
11.00	01100	CAFETERIA	0	859,934	2,710	0	1,626	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,506,617	2,720	0	1,222	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,278,661	4,195	0	2,471	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	4,683,427	23,328	174,612	15,690	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,090,955	5,095	14,311	2,021	31.00
43.00	04300	NURSERY	0	138,238	1,221	0	186	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	7,780,290	27,479	28,461	3,269	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	539,406	615	0	820	52.00
53.00	05300	ANESTHESIOLOGY	0	229,736	461	0	33	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,901,459	8,015	17,909	1,215	54.00
54.01	05402	NUCLEAR MEDICINE	0	698,751	2,098	0	73	54.01
57.00	05700	CT SCAN	0	583,509	650	3,571	73	57.00
60.00	06000	LABORATORY	0	3,321,710	3,909	134	819	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	213,525	234	0	86	63.00
65.00	06500	RESPIRATORY THERAPY	0	620,635	1,560	524	198	65.00
66.00	06600	PHYSICAL THERAPY	0	1,854,253	10,457	14,311	407	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	192,233	39	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	102,039	176	0	73	68.00
69.00	06900	ELECTROCARDIOLOGY	0	243,232	132	0	127	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	147,071	1,332	0	29	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	376,328	7,396	0	198	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,318,082	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,604,277	2,860	0	819	73.00
76.00	03020	SONOGRAPHY	0	645,977	535	0	73	76.00
76.01	03040	AUDIOLOGY	0	201,508	0	0	73	76.01
76.02	03160	CARDIAC REHAB	0	260,167	1,491	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	14,299,044	16,960	0	0	90.00
91.00	09100	EMERGENCY	0	2,163,662	9,803	14,311	819	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	855,919	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	1,473,863	974	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-13,127,133	59,348,981	148,290	268,144	34,459	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,772	1,335	0	73	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	0	0	194.00
194.01	07951	CONGREGATE LIVING	0	162,609	13,274	0	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	0	80,228	0	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	0	69,218	7,850	0	6,525	194.04
194.05	07955	SPECIALTY CLINICS	0	3,687	0	354	0	194.05
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	761,424	2,900	0	0	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018

Worksheet B-1

Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Description			Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
			5A	5.00	7.00	8.00	9.00	
194.20	07970	PARATRANSIT	0	206,494	0	0	0	194.20
194.21	07971	OCCUPATIONAL HEALTH	0	282,172	0	0	0	194.21
194.24	07974	SURGICAL ASSOCIATES	0	430	0	0	0	194.24
194.27	07977	MIDTOWN	0	3,689	0	0	0	194.27
194.28	07978	PAIN CLINIC	0	198,165	0	0	0	194.28
194.30	07980	WHC-PTON	0	0	0	0	0	194.30
194.31	07981	CFH	0	0	0	0	0	194.31
194.32	07982	PFS	0	0	0	0	0	194.32
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)		13,127,133	3,065,929	284,917	1,233,447	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.214745	17.655898	1.061151	30.042307	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		1,920,837	357,138	15,655	80,088	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.031423	2.056666	0.058306	1.950654	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: 14-0143

Period:
From 10/01/2017
To 09/30/2018

Worksheet B-1

Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Description			DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	MEDICAL RECORDS & LIBRARY (PATIENT CHARGES)	SOCIAL SERVICE (TIME SPENT)	
			10.00	11.00	13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	23,978					10.00
11.00	01100	CAFETERIA	0	25,738				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,118	253,239			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,137	0	249,798,700		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,847	5,311	110,476	13,263,011	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,027	1,098	22,839	1,814,673	0	31.00
43.00	04300	NURSERY	0	165	3,434	752,725	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1	3,542	73,670	37,417,903	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		517	10,744	1,246,101	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	7,014,185	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,592	0	17,013,893	0	54.00
54.01	05402	NUCLEAR MEDICINE	0	219	0	3,153,201	0	54.01
57.00	05700	CT SCAN	0	145	0	18,064,855	0	57.00
60.00	06000	LABORATORY	0	2,035	0	39,303,336	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	436,200	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	693	0	3,783,345	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	10,417,549	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,051,946	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	458,767	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	156	0	5,510,071	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	104	0	1,406,156	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	115	0	11,865,240	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,459,614	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	936	0	7,594,794	0	73.00
76.00	03020	SONOGRAPHY	0	244	0	7,910,454	0	76.00
76.01	03040	AUDIOLOGY	0	0	0	458,352	0	76.01
76.02	03160	CARDIAC REHAB	0	0	0	1,154,012	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	1,822	0	7,737,374	0	90.00
91.00	09100	EMERGENCY	0	1,542	32,076	10,741,357	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	865,980	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	859	0	4,380,527	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,875	25,350	253,239	219,275,621	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	8,005,746	0	194.00
194.01	07951	CONGREGATE LIVING	5,103	84	0	0	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	3,602,763	0	194.02
194.03	07953	MANAGED CARE	0	64	0	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	0	0	0	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	0	0	492,913	0	194.05
194.08	07958	ENT	0	0	0	1,892,119	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	0	0	698,587	0	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	3,479,405	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	3,244,673	0	194.13
194.14	07964	HENRY	0	0	0	131,804	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	113,734	0	194.16
194.17	07967	OGLESBY MP OB	0	0	0	162,124	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	2,608,101	0	194.18

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018

Worksheet B-1

Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Description			DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	MEDICAL RECORDS & LIBRARY (PATIENT CHARGES)	SOCIAL SERVICE (TIME SPENT)	
			10.00	11.00	13.00	16.00	17.00	
194.19	07969	GRANVILLE CLINIC	0	0	0	420,374	0	194.19
194.20	07970	PARATRANSIT	0	0	0	0	0	194.20
194.21	07971	OCCUPATIONAL HEALTH	0	240	0	441,013	0	194.21
194.24	07974	SURGICAL ASSOCIATES	0	0	0	0	0	194.24
194.27	07977	MIDTOWN	0	0	0	3,418,563	0	194.27
194.28	07978	PAIN CLINIC	0	0	0	110,058	0	194.28
194.30	07980	WHC-PTON	0	0	0	0	0	194.30
194.31	07981	CFH	0	0	0	1,701,102	0	194.31
194.32	07982	PFS	0	0	0	0	0	194.32
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)	744,871	1,141,297	1,964,466	3,055,397	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	31.064768	44.342878	7.757360	0.012231	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	125,506	59,868	86,439	150,158	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.234215	2.326055	0.341334	0.000601	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet C
Part I
Date/Time Prepared:
2/27/2019 1:34 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE	Total Costs	
						Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,504,711		8,504,711	55,983	8,560,694	30.00
31.00	03100	INTENSIVE CARE UNIT	1,833,177		1,833,177	0	1,833,177	31.00
43.00	04300	NURSERY	238,233		238,233	0	238,233	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,250,879		11,250,879	0	11,250,879	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	812,245		812,245	0	812,245	52.00
53.00	05300	ANESTHESIOLOGY	373,991		373,991	225,335	599,326	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,000,241		4,000,241	0	4,000,241	54.00
54.01	05402	NUCLEAR MEDICINE	936,317		936,317	0	936,317	54.01
57.00	05700	CT SCAN	953,654		953,654	0	953,654	57.00
60.00	06000	LABORATORY	4,699,860		4,699,860	0	4,699,860	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	271,428		271,428	0	271,428	63.00
65.00	06500	RESPIRATORY THERAPY	864,964	0	864,964	0	864,964	65.00
66.00	06600	PHYSICAL THERAPY	2,591,903	0	2,591,903	0	2,591,903	66.00
67.00	06700	OCCUPATIONAL THERAPY	247,069	0	247,069	0	247,069	67.00
68.00	06800	SPEECH PATHOLOGY	134,862	0	134,862	0	134,862	68.00
69.00	06900	ELECTROCARDIOLOGY	375,922		375,922	0	375,922	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	224,854		224,854	0	224,854	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	743,897		743,897	0	743,897	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,870,425		2,870,425	0	2,870,425	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,373,030		3,373,030	0	3,373,030	73.00
76.00	03020	SONOGRAPHY	903,909		903,909	0	903,909	76.00
76.01	03040	AUDIOLOGY	252,580		252,580	0	252,580	76.01
76.02	03160	CARDIAC REHAB	356,477		356,477	0	356,477	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
90.00	09000	CLINIC	17,844,577		17,844,577	0	17,844,577	90.00
91.00	09100	EMERGENCY	3,289,750		3,289,750	426,945	3,716,695	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,693,438		2,693,438	0	2,693,438	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,050,315		1,050,315	0	1,050,315	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	1,899,234		1,899,234		1,899,234	116.00
200.00		Subtotal (see instructions)	73,591,942	0	73,591,942	708,263	74,300,205	200.00
201.00		Less Observation Beds	2,693,438		2,693,438		2,693,438	201.00
202.00		Total (see instructions)	70,898,504	0	70,898,504	708,263	71,606,767	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet C
Part I
Date/Time Prepared:
2/27/2019 1:34 pm

			Title XVIII		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,517,958		8,517,958		30.00
31.00	03100	INTENSIVE CARE UNIT	1,809,482		1,809,482		31.00
43.00	04300	NURSERY	746,793		746,793		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,476,535	28,656,351	37,132,886	0.302990	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,045,274	191,334	1,236,608	0.656833	52.00
53.00	05300	ANESTHESIOLOGY	2,220,982	4,731,423	6,952,405	0.053793	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,662,179	15,260,436	16,922,615	0.236384	54.00
54.01	05402	NUCLEAR MEDICINE	187,801	2,950,454	3,138,255	0.298356	54.01
57.00	05700	CT SCAN	2,488,099	15,489,843	17,977,942	0.053046	57.00
60.00	06000	LABORATORY	7,307,566	31,811,982	39,119,548	0.120141	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	253,100	182,178	435,278	0.623574	63.00
65.00	06500	RESPIRATORY THERAPY	2,786,342	987,839	3,774,181	0.229179	65.00
66.00	06600	PHYSICAL THERAPY	903,816	9,462,890	10,366,706	0.250022	66.00
67.00	06700	OCCUPATIONAL THERAPY	134,451	911,983	1,046,434	0.236106	67.00
68.00	06800	SPEECH PATHOLOGY	39,386	417,218	456,604	0.295359	68.00
69.00	06900	ELECTROCARDIOLOGY	2,000,063	3,493,647	5,493,710	0.068428	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,212	1,391,075	1,394,287	0.161268	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,662,570	4,176,109	11,838,679	0.062836	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,057,780	401,834	4,459,614	0.643649	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,231,435	4,314,819	7,546,254	0.446981	73.00
76.00	03020	SONOGRAPHY	1,025,464	6,844,540	7,870,004	0.114855	76.00
76.01	03040	AUDIOLOGY	0	458,352	458,352	0.551061	76.01
76.02	03160	CARDIAC REHAB	28,686	1,118,807	1,147,493	0.310657	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	75,000	7,606,479	7,681,479	2.323065	90.00
91.00	09100	EMERGENCY	1,730,784	8,970,358	10,701,142	0.307420	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,079,346	3,626,123	4,705,469	0.572406	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	863,863	863,863	1.215835	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	4,379,703	4,379,703		116.00
200.00		Subtotal (see instructions)	59,474,104	158,699,640	218,173,744		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	59,474,104	158,699,640	218,173,744		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet C
Part I
Date/Time Prepared:
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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	0.302990			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.656833			52.00
53.00	05300	ANESTHESIOLOGY	0.086204			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.236384			54.00
54.01	05402	NUCLEAR MEDICINE	0.298356			54.01
57.00	05700	CT SCAN	0.053046			57.00
60.00	06000	LABORATORY	0.120141			60.00
60.01	06001	BLOOD LABORATORY	0.000000			60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.623574			63.00
65.00	06500	RESPIRATORY THERAPY	0.229179			65.00
66.00	06600	PHYSICAL THERAPY	0.250022			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.236106			67.00
68.00	06800	SPEECH PATHOLOGY	0.295359			68.00
69.00	06900	ELECTROCARDIOLOGY	0.068428			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.161268			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.062836			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.643649			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.446981			73.00
76.00	03020	SONOGRAPHY	0.114855			76.00
76.01	03040	AUDIOLOGY	0.551061			76.01
76.02	03160	CARDIAC REHAB	0.310657			76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	2.323065			90.00
91.00	09100	EMERGENCY	0.347318			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.572406			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000			93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1.215835			95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
114.00	11400	UTILIZATION REVIEW-SNF				114.00
116.00	11600	HOSPICE				116.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

Worksheet C
Part I
Date/Time Prepared:
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				Title XIX		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	8,504,711		8,504,711	55,983	8,560,694	30.00	
31.00	03100	INTENSIVE CARE UNIT	1,833,177		1,833,177	0	1,833,177	31.00	
43.00	04300	NURSERY	238,233		238,233	0	238,233	43.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	11,250,879		11,250,879	0	11,250,879	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	812,245		812,245	0	812,245	52.00	
53.00	05300	ANESTHESIOLOGY	373,991		373,991	225,335	599,326	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,000,241		4,000,241	0	4,000,241	54.00	
54.01	05402	NUCLEAR MEDICINE	936,317		936,317	0	936,317	54.01	
57.00	05700	CT SCAN	953,654		953,654	0	953,654	57.00	
60.00	06000	LABORATORY	4,699,860		4,699,860	0	4,699,860	60.00	
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	271,428		271,428	0	271,428	63.00	
65.00	06500	RESPIRATORY THERAPY	864,964	0	864,964	0	864,964	65.00	
66.00	06600	PHYSICAL THERAPY	2,591,903	0	2,591,903	0	2,591,903	66.00	
67.00	06700	OCCUPATIONAL THERAPY	247,069	0	247,069	0	247,069	67.00	
68.00	06800	SPEECH PATHOLOGY	134,862	0	134,862	0	134,862	68.00	
69.00	06900	ELECTROCARDIOLOGY	375,922		375,922	0	375,922	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	224,854		224,854	0	224,854	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	743,897		743,897	0	743,897	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,870,425		2,870,425	0	2,870,425	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	3,373,030		3,373,030	0	3,373,030	73.00	
76.00	03020	SONOGRAPHY	903,909		903,909	0	903,909	76.00	
76.01	03040	AUDIOLOGY	252,580		252,580	0	252,580	76.01	
76.02	03160	CARDIAC REHAB	356,477		356,477	0	356,477	76.02	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00	
90.00	09000	CLINIC	17,844,577		17,844,577	0	17,844,577	90.00	
91.00	09100	EMERGENCY	3,289,750		3,289,750	426,945	3,716,695	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,693,438		2,693,438	0	2,693,438	92.00	
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	1,050,315		1,050,315	0	1,050,315	95.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
114.00	11400	UTILIZATION REVIEW-SNF						114.00	
116.00	11600	HOSPICE	1,899,234		1,899,234		1,899,234	116.00	
200.00		Subtotal (see instructions)	73,591,942	0	73,591,942	708,263	74,300,205	200.00	
201.00		Less Observation Beds	2,693,438		2,693,438		2,693,438	201.00	
202.00		Total (see instructions)	70,898,504	0	70,898,504	708,263	71,606,767	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet C
Part I
Date/Time Prepared:
2/27/2019 1:34 pm

			Title XIX			Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,517,958		8,517,958			30.00
31.00	03100	INTENSIVE CARE UNIT	1,809,482		1,809,482			31.00
43.00	04300	NURSERY	746,793		746,793			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,476,535	28,656,351	37,132,886	0.302990	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,045,274	191,334	1,236,608	0.656833	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	2,220,982	4,731,423	6,952,405	0.053793	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,662,179	15,260,436	16,922,615	0.236384	0.000000	54.00
54.01	05402	NUCLEAR MEDICINE	187,801	2,950,454	3,138,255	0.298356	0.000000	54.01
57.00	05700	CT SCAN	2,488,099	15,489,843	17,977,942	0.053046	0.000000	57.00
60.00	06000	LABORATORY	7,307,566	31,811,982	39,119,548	0.120141	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	253,100	182,178	435,278	0.623574	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	2,786,342	987,839	3,774,181	0.229179	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	903,816	9,462,890	10,366,706	0.250022	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	134,451	911,983	1,046,434	0.236106	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	39,386	417,218	456,604	0.295359	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,000,063	3,493,647	5,493,710	0.068428	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,212	1,391,075	1,394,287	0.161268	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,662,570	4,176,109	11,838,679	0.062836	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,057,780	401,834	4,459,614	0.643649	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,231,435	4,314,819	7,546,254	0.446981	0.000000	73.00
76.00	03020	SONOGRAPHY	1,025,464	6,844,540	7,870,004	0.114855	0.000000	76.00
76.01	03040	AUDIOLOGY	0	458,352	458,352	0.551061	0.000000	76.01
76.02	03160	CARDIAC REHAB	28,686	1,118,807	1,147,493	0.310657	0.000000	76.02
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
90.00	09000	CLINIC	75,000	7,606,479	7,681,479	2.323065	0.000000	90.00
91.00	09100	EMERGENCY	1,730,784	8,970,358	10,701,142	0.307420	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,079,346	3,626,123	4,705,469	0.572406	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	863,863	863,863	1.215835	0.000000	95.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	4,379,703	4,379,703			116.00
200.00		Subtotal (see instructions)	59,474,104	158,699,640	218,173,744			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	59,474,104	158,699,640	218,173,744			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0143	Period: From 10/01/2017 To 09/30/2018	Worksheet C Part I Date/Time Prepared: 2/27/2019 1:34 pm
			Title XIX	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio		
			11.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.302990		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.656833		52.00
53.00	05300	ANESTHESIOLOGY	0.086204		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.236384		54.00
54.01	05402	NUCLEAR MEDICINE	0.298356		54.01
57.00	05700	CT SCAN	0.053046		57.00
60.00	06000	LABORATORY	0.120141		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.623574		63.00
65.00	06500	RESPIRATORY THERAPY	0.229179		65.00
66.00	06600	PHYSICAL THERAPY	0.250022		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.236106		67.00
68.00	06800	SPEECH PATHOLOGY	0.295359		68.00
69.00	06900	ELECTROCARDIOLOGY	0.068428		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.161268		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.062836		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.643649		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.446981		73.00
76.00	03020	SONOGRAPHY	0.114855		76.00
76.01	03040	AUDIOLOGY	0.551061		76.01
76.02	03160	CARDIAC REHAB	0.310657		76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	2.323065		90.00
91.00	09100	EMERGENCY	0.347318		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.572406		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	1.215835		95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet C
Part II
Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Description			Title XIX		Hospital		PPS
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	11,250,879	1,167,624	10,083,255	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	812,245	48,964	763,281	0	0
53.00	05300	ANESTHESIOLOGY	373,991	54,556	319,435	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,000,241	832,120	3,168,121	0	0
54.01	05402	NUCLEAR MEDICINE	936,317	138,618	797,699	0	0
57.00	05700	CT SCAN	953,654	194,155	759,499	0	0
60.00	06000	LABORATORY	4,699,860	225,000	4,474,860	0	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	271,428	9,684	261,744	0	0
65.00	06500	RESPIRATORY THERAPY	864,964	72,378	792,586	0	0
66.00	06600	PHYSICAL THERAPY	2,591,903	192,463	2,399,440	0	0
67.00	06700	OCCUPATIONAL THERAPY	247,069	7,148	239,921	0	0
68.00	06800	SPEECH PATHOLOGY	134,862	5,565	129,297	0	0
69.00	06900	ELECTROCARDIOLOGY	375,922	27,019	348,903	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	224,854	20,264	204,590	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	743,897	125,513	618,384	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,870,425	75,521	2,794,904	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	3,373,030	162,261	3,210,769	0	0
76.00	03020	SONOGRAPHY	903,909	80,236	823,673	0	0
76.01	03040	AUDIOLOGY	252,580	6,749	245,831	0	0
76.02	03160	CARDIAC REHAB	356,477	33,480	322,997	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
90.00	09000	CLINIC	17,844,577	1,005,351	16,839,226	0	0
91.00	09100	EMERGENCY	3,289,750	333,036	2,956,714	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,693,438	239,188	2,454,250	0	0
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,050,315	27,416	1,022,899	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	1,899,234	110,962	1,788,272	0	0
200.00		Subtotal (sum of lines 50 thru 199)	63,015,821	5,195,271	57,820,550	0	0
201.00		Less Observation Beds	2,693,438	239,188	2,454,250	0	0
202.00		Total (line 200 minus line 201)	60,322,383	4,956,083	55,366,300	0	0

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

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018

Worksheet C
Part II
Date/Time Prepared:
2/27/2019 1:34 pm

				Title XIX		Hospital	PPS
Cost Center Description				Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
				6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		11,250,879	37,132,886	0.302990	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		812,245	1,236,608	0.656833	52.00
53.00	05300	ANESTHESIOLOGY		373,991	6,952,405	0.053793	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		4,000,241	16,922,615	0.236384	54.00
54.01	05402	NUCLEAR MEDICINE		936,317	3,138,255	0.298356	54.01
57.00	05700	CT SCAN		953,654	17,977,942	0.053046	57.00
60.00	06000	LABORATORY		4,699,860	39,119,548	0.120141	60.00
60.01	06001	BLOOD LABORATORY		0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		271,428	435,278	0.623574	63.00
65.00	06500	RESPIRATORY THERAPY		864,964	3,774,181	0.229179	65.00
66.00	06600	PHYSICAL THERAPY		2,591,903	10,366,706	0.250022	66.00
67.00	06700	OCCUPATIONAL THERAPY		247,069	1,046,434	0.236106	67.00
68.00	06800	SPEECH PATHOLOGY		134,862	456,604	0.295359	68.00
69.00	06900	ELECTROCARDIOLOGY		375,922	5,493,710	0.068428	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		224,854	1,394,287	0.161268	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		743,897	11,838,679	0.062836	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		2,870,425	4,459,614	0.643649	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		3,373,030	7,546,254	0.446981	73.00
76.00	03020	SONOGRAPHY		903,909	7,870,004	0.114855	76.00
76.01	03040	AUDIOLOGY		252,580	458,352	0.551061	76.01
76.02	03160	CARDIAC REHAB		356,477	1,147,493	0.310657	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC		0	0	0.000000	88.00
90.00	09000	CLINIC		17,844,577	7,681,479	2.323065	90.00
91.00	09100	EMERGENCY		3,289,750	10,701,142	0.307420	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		2,693,438	4,705,469	0.572406	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER		0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES		1,050,315	863,863	1.215835	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE		1,899,234	4,379,703	0.433644	116.00
200.00		Subtotal (sum of lines 50 thru 199)		63,015,821	207,099,511		200.00
201.00		Less Observation Beds		2,693,438	0		201.00
202.00		Total (line 200 minus line 201)		60,322,383	207,099,511		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet D
Part I
Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	PPS
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		760,221	297	759,924	8,054	94.35	30.00
31.00	INTENSIVE CARE UNIT		155,490		155,490	808	192.44	31.00
43.00	NURSERY		55,313		55,313	640	86.43	43.00
200.00	Total (lines 30 through 199)		971,024		970,727	9,502		200.00
Cost Center Description			Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
			6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		3,307	312,015				
31.00	INTENSIVE CARE UNIT		513	98,722				
43.00	NURSERY		0	0				
200.00	Total (lines 30 through 199)		3,820	410,737				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet D
Part II
Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Description			Title XVIII		Hospital	PPS		
			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	1,167,624	37,132,886	0.031444	4,162,570	130,888	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	48,964	1,236,608	0.039595	2,198	87	52.00
53.00	05300	ANESTHESIOLOGY	54,556	6,952,405	0.007847	1,198,732	9,406	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	832,120	16,922,615	0.049172	1,387,485	68,225	54.00
54.01	05402	NUCLEAR MEDICINE	138,618	3,138,255	0.044170	153,352	6,774	54.01
57.00	05700	CT SCAN	194,155	17,977,942	0.010800	1,689,895	18,251	57.00
60.00	06000	LABORATORY	225,000	39,119,548	0.005752	4,718,521	27,141	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	9,684	435,278	0.022248	174,628	3,885	63.00
65.00	06500	RESPIRATORY THERAPY	72,378	3,774,181	0.019177	819,111	15,708	65.00
66.00	06600	PHYSICAL THERAPY	192,463	10,366,706	0.018565	567,683	10,539	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,148	1,046,434	0.006831	71,209	486	67.00
68.00	06800	SPEECH PATHOLOGY	5,565	456,604	0.012188	32,661	398	68.00
69.00	06900	ELECTROCARDIOLOGY	27,019	5,493,710	0.004918	1,502,844	7,391	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	20,264	1,394,287	0.014534	2,926	43	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	125,513	11,838,679	0.010602	6,497,808	68,890	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	75,521	4,459,614	0.016934	1,936,308	32,789	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	162,261	7,546,254	0.021502	1,868,159	40,169	73.00
76.00	03020	SONOGRAPHY	80,236	7,870,004	0.010195	632,208	6,445	76.00
76.01	03040	AUDIOLOGY	6,749	458,352	0.014724	0	0	76.01
76.02	03160	CARDIAC REHAB	33,480	1,147,493	0.029177	0	0	76.02
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
90.00	09000	CLINIC	1,005,351	7,681,479	0.130880	74,286	9,723	90.00
91.00	09100	EMERGENCY	333,036	10,701,142	0.031122	1,363,000	42,419	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	239,188	4,705,469	0.050832	185,965	9,453	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	5,056,893	201,855,945		29,041,549	509,110	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS						Provider CCN: 14-0143		Period: From 10/01/2017 To 09/30/2018		Worksheet D Part III Date/Time Prepared: 2/27/2019 1:34 pm		
						Title XVIII		Hospital		PPS		
Cost Center Description						Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
						1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS												
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	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	8,054	0.00	3,307			30.00	
31.00	03100	INTENSIVE CARE UNIT			0	808	0.00	513			31.00	
43.00	04300	NURSERY			0	640	0.00	0			43.00	
200.00		Total (lines 30 through 199)			0	9,502		3,820			200.00	
Cost Center Description						Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
						9.00						
INPATIENT ROUTINE SERVICE COST CENTERS												
30.00	03000	ADULTS & PEDIATRICS		0							30.00	
31.00	03100	INTENSIVE CARE UNIT		0							31.00	
43.00	04300	NURSERY		0							43.00	
200.00		Total (lines 30 through 199)		0							200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet D
Part IV
Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Description			Title XVIII		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05402	NUCLEAR MEDICINE	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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
76.00	03020	SONOGRAPHY	0	0	0	0	0	76.00
76.01	03040	AUDIOLOGY	0	0	0	0	0	76.01
76.02	03160	CARDIAC REHAB	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet D
Part IV
Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Description		Title XVIII			Hospital		PPS	
		All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	37,132,886	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,236,608	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	6,952,405	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	16,922,615	0.000000	54.00
54.01	05402	NUCLEAR MEDICINE	0	0	0	3,138,255	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	17,977,942	0.000000	57.00
60.00	06000	LABORATORY	0	0	0	39,119,548	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	435,278	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,774,181	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	10,366,706	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,046,434	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	456,604	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	5,493,710	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,394,287	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	11,838,679	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,459,614	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,546,254	0.000000	73.00
76.00	03020	SONOGRAPHY	0	0	0	7,870,004	0.000000	76.00
76.01	03040	AUDIOLOGY	0	0	0	458,352	0.000000	76.01
76.02	03160	CARDIAC REHAB	0	0	0	1,147,493	0.000000	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
90.00	09000	CLINIC	0	0	0	7,681,479	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	10,701,142	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	4,705,469	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	201,855,945		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet D
Part IV
Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Description		Title XVIII			Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	4,162,570	0	8,037,084	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	2,198	0	143	0 52.00
53.00	05300	ANESTHESIOLOGY	0.000000	1,198,732	0	1,540,152	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,387,485	0	6,116,452	0 54.00
54.01	05402	NUCLEAR MEDICINE	0.000000	153,352	0	1,537,918	0 54.01
57.00	05700	CT SCAN	0.000000	1,689,895	0	5,411,015	0 57.00
60.00	06000	LABORATORY	0.000000	4,718,521	0	4,411,936	0 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0 60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	174,628	0	69,546	0 63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	819,111	0	454,615	0 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	567,683	0	28,963	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	71,209	0	2,503	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	32,661	0	1,398	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,502,844	0	1,463,613	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	2,926	0	133,003	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	6,497,808	0	1,976,097	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,936,308	0	191,749	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,868,159	0	2,594,803	0 73.00
76.00	03020	SONOGRAPHY	0.000000	632,208	0	1,659,083	0 76.00
76.01	03040	AUDIOLOGY	0.000000	0	0	70,796	0 76.01
76.02	03160	CARDIAC REHAB	0.000000	0	0	119,664	0 76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0 88.00
90.00	09000	CLINIC	0.000000	74,286	0	1,534,466	0 90.00
91.00	09100	EMERGENCY	0.000000	1,363,000	0	2,523,388	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	185,965	0	837,858	0 92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0 93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)		29,041,549	0	40,716,245	0 200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0143		Period: From 10/01/2017 To 09/30/2018		Worksheet D Part V Date/Time Prepared: 2/27/2019 1:34 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description				Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
					PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
				1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.302990	8,037,084	0	0	2,435,156	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.656833	143	0	0	94	52.00
53.00	05300	ANESTHESIOLOGY		0.053793	1,540,152	0	0	82,849	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.236384	6,116,452	0	0	1,445,831	54.00
54.01	05402	NUCLEAR MEDICINE		0.298356	1,537,918	0	0	458,847	54.01
57.00	05700	CT SCAN		0.053046	5,411,015	0	0	287,033	57.00
60.00	06000	LABORATORY		0.120141	4,411,936	0	0	530,054	60.00
60.01	06001	BLOOD LABORATORY		0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0.623574	69,546	0	0	43,367	63.00
65.00	06500	RESPIRATORY THERAPY		0.229179	454,615	0	0	104,188	65.00
66.00	06600	PHYSICAL THERAPY		0.250022	28,963	0	0	7,241	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.236106	2,503	0	0	591	67.00
68.00	06800	SPEECH PATHOLOGY		0.295359	1,398	0	0	413	68.00
69.00	06900	ELECTROCARDIOLOGY		0.068428	1,463,613	0	0	100,152	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.161268	133,003	0	0	21,449	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.062836	1,976,097	0	0	124,170	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.643649	191,749	0	0	123,419	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.446981	2,594,803	1,296	95,921	1,159,828	73.00
76.00	03020	SONOGRAPHY		0.114855	1,659,083	0	0	190,554	76.00
76.01	03040	AUDIOLOGY		0.551061	70,796	0	0	39,013	76.01
76.02	03160	CARDIAC REHAB		0.310657	119,664	0	0	37,174	76.02
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0.000000		0	0	0	88.00
90.00	09000	CLINIC		2.323065	1,534,466	0	0	3,564,664	90.00
91.00	09100	EMERGENCY		0.307420	2,523,388	0	0	775,740	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.572406	837,858	0	0	479,595	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER		0.000000	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES		1.215835		0			95.00
200.00		Subtotal (see instructions)			40,716,245	1,296	95,921	12,011,422	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0		201.00
202.00		Net Charges (line 200 - line 201)			40,716,245	1,296	95,921	12,011,422	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0143		Period: From 10/01/2017 To 09/30/2018	Worksheet D Part V Date/Time Prepared: 2/27/2019 1:34 pm
			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05402	NUCLEAR MEDICINE	0	0		54.01
57.00	05700	CT SCAN	0	0		57.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
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	579	42,875		73.00
76.00	03020	SONOGRAPHY	0	0		76.00
76.01	03040	AUDIOLOGY	0	0		76.01
76.02	03160	CARDIAC REHAB	0	0		76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
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
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	579	42,875		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	579	42,875		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet D
Part I
Date/Time Prepared:
2/27/2019 1:34 pm

			Title XIX		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	760,221	297	759,924	8,054	94.35	30.00
31.00	INTENSIVE CARE UNIT	155,490		155,490	808	192.44	31.00
43.00	NURSERY	55,313		55,313	640	86.43	43.00
200.00	Total (lines 30 through 199)	971,024		970,727	9,502		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	378	35,664				30.00
31.00	INTENSIVE CARE UNIT	20	3,849				31.00
43.00	NURSERY	210	18,150				43.00
200.00	Total (lines 30 through 199)	608	57,663				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet D
Part II
Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Description		Title XIX		Hospital		PPS	
		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	1,167,624	37,132,886	0.031444	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	48,964	1,236,608	0.039595	0	52.00
53.00	05300	ANESTHESIOLOGY	54,556	6,952,405	0.007847	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	832,120	16,922,615	0.049172	0	54.00
54.01	05402	NUCLEAR MEDICINE	138,618	3,138,255	0.044170	0	54.01
57.00	05700	CT SCAN	194,155	17,977,942	0.010800	0	57.00
60.00	06000	LABORATORY	225,000	39,119,548	0.005752	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	9,684	435,278	0.022248	0	63.00
65.00	06500	RESPIRATORY THERAPY	72,378	3,774,181	0.019177	0	65.00
66.00	06600	PHYSICAL THERAPY	192,463	10,366,706	0.018565	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,148	1,046,434	0.006831	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,565	456,604	0.012188	0	68.00
69.00	06900	ELECTROCARDIOLOGY	27,019	5,493,710	0.004918	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	20,264	1,394,287	0.014534	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	125,513	11,838,679	0.010602	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	75,521	4,459,614	0.016934	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	162,261	7,546,254	0.021502	0	73.00
76.00	03020	SONOGRAPHY	80,236	7,870,004	0.010195	0	76.00
76.01	03040	AUDIOLOGY	6,749	458,352	0.014724	0	76.01
76.02	03160	CARDIAC REHAB	33,480	1,147,493	0.029177	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	88.00
90.00	09000	CLINIC	1,005,351	7,681,479	0.130880	0	90.00
91.00	09100	EMERGENCY	333,036	10,701,142	0.031122	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	239,188	4,705,469	0.050832	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)	5,056,893	201,855,945		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0143		Period: From 10/01/2017 To 09/30/2018		Worksheet D Part III Date/Time Prepared: 2/27/2019 1:34 pm	
					Title XIX		Hospital		PPS	
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
					1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00	
43.00	04300	NURSERY	0	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
					4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	8,054	0.00	378	30.00		
31.00	03100	INTENSIVE CARE UNIT		0	808	0.00	20	31.00		
43.00	04300	NURSERY		0	640	0.00	210	43.00		
200.00		Total (lines 30 through 199)		0	9,502		608	200.00		
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
					9.00					
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	30.00						
31.00	03100	INTENSIVE CARE UNIT	0	31.00						
43.00	04300	NURSERY	0	43.00						
200.00		Total (lines 30 through 199)	0	200.00						

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet D
Part IV
Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Description			Title XIX		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05402	NUCLEAR MEDICINE	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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
76.00	03020	SONOGRAPHY	0	0	0	0	0	76.00
76.01	03040	AUDIOLOGY	0	0	0	0	0	76.01
76.02	03160	CARDIAC REHAB	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet D
Part IV
Date/Time Prepared:
2/27/2019 1:34 pm

				Title XIX		Hospital	PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	37,132,886	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,236,608	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	6,952,405	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	16,922,615	0.000000	54.00
54.01	05402	NUCLEAR MEDICINE	0	0	0	3,138,255	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	17,977,942	0.000000	57.00
60.00	06000	LABORATORY	0	0	0	39,119,548	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	435,278	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,774,181	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	10,366,706	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,046,434	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	456,604	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	5,493,710	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,394,287	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	11,838,679	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,459,614	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,546,254	0.000000	73.00
76.00	03020	SONOGRAPHY	0	0	0	7,870,004	0.000000	76.00
76.01	03040	AUDIOLOGY	0	0	0	458,352	0.000000	76.01
76.02	03160	CARDIAC REHAB	0	0	0	1,147,493	0.000000	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
90.00	09000	CLINIC	0	0	0	7,681,479	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	10,701,142	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	4,705,469	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	201,855,945		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet D
Part IV
Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Description		Title XIX		Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	54.00
54.01	05402	NUCLEAR MEDICINE	0.000000	0	0	0	54.01
57.00	05700	CT SCAN	0.000000	0	0	0	57.00
60.00	06000	LABORATORY	0.000000	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	73.00
76.00	03020	SONOGRAPHY	0.000000	0	0	0	76.00
76.01	03040	AUDIOLOGY	0.000000	0	0	0	76.01
76.02	03160	CARDIAC REHAB	0.000000	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES		0	0	0	95.00
200.00		Total (lines 50 through 199)		0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0143	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/27/2019 1:34 pm
Cost Center Description		Title XVIII	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		8,069	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		8,054	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)		5,519	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		3	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)		12	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		3,307	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)		3	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)		12	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		218.85	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		224.47	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)		8,560,694	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)		657	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)		2,694	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)		3,351	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		8,557,343	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		8,557,343	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,062.50	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,513,688	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		3,513,688	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018

Worksheet D-1

Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Description		Title XVIII			Hospital		PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT	1,833,177	808	2,268.78	513	1,163,884		43.00
44.00	CORONARY CARE UNIT							44.00
45.00	BURN INTENSIVE CARE UNIT							45.00
46.00	SURGICAL INTENSIVE CARE UNIT							46.00
47.00	OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					6,279,231		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					10,956,803		49.00
PASS THROUGH COST ADJUSTMENTS								
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					410,737		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					509,110		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					919,847		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					10,036,956		53.00
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges					0		54.00
55.00	Target amount per discharge					0.00		55.00
56.00	Target amount (line 54 x line 55)					0		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00	Bonus payment (see instructions)					0		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00	Relief payment (see instructions)					0		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					657		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					2,694		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					3,351		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
87.00	Total observation bed days (see instructions)					2,535		87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,062.50		88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,693,438		89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018

Worksheet D-1

Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Description		Title XVIII		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	760,221	8,560,694	0.088804	2,693,438	239,188
91.00	Nursing School cost	0	8,560,694	0.000000	2,693,438	0
92.00	Allied health cost	0	8,560,694	0.000000	2,693,438	0
93.00	All other Medical Education	0	8,560,694	0.000000	2,693,438	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0143	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/27/2019 1:34 pm
Cost Center Description		Title XIX	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		8,069	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		8,054	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)		5,519	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		3	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)		12	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)		378	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)		640	15.00
16.00	Nursery days (title V or XIX only)		210	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		218.85	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		224.47	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)		8,560,694	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)		657	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)		2,694	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)		3,351	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		8,557,343	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		8,557,343	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,062.50	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		401,625	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)		401,625	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018

Worksheet D-1

Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospital Program Days	PPS Program Cost (col. 3 x col. 4)		
		1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	238,233	640	372.24	210	78,170	42.00	
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT	1,833,177	808	2,268.78	20	45,376	43.00	
44.00	CORONARY CARE UNIT						44.00	
45.00	BURN INTENSIVE CARE UNIT						45.00	
46.00	SURGICAL INTENSIVE CARE UNIT						46.00	
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00	
Cost Center Description								
							1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						525,171	49.00
PASS THROUGH COST ADJUSTMENTS								
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						57,663	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						57,663	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						467,508	53.00
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges						0	54.00
55.00	Target amount per discharge						0.00	55.00
56.00	Target amount (line 54 x line 55)						0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00	Bonus payment (see instructions)						0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00	Relief payment (see instructions)						0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
87.00	Total observation bed days (see instructions)						2,535	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,062.50	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						2,693,438	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018

Worksheet D-1

Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Description		Title XIX		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	760,221	8,560,694	0.088804	2,693,438	239,188
91.00	Nursing School cost	0	8,560,694	0.000000	2,693,438	0
92.00	Allied health cost	0	8,560,694	0.000000	2,693,438	0
93.00	All other Medical Education	0	8,560,694	0.000000	2,693,438	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0143	Period: From 10/01/2017 To 09/30/2018	Worksheet D-3 Date/Time Prepared: 2/27/2019 1:34 pm	
			Title XVIII	Hospital	PPS	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		4,645,325		30.00
31.00	03100	INTENSIVE CARE UNIT		1,245,020		31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.302990	4,162,570	1,261,217	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.656833	2,198	1,444	52.00
53.00	05300	ANESTHESIOLOGY	0.086204	1,198,732	103,335	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.236384	1,387,485	327,979	54.00
54.01	05402	NUCLEAR MEDICINE	0.298356	153,352	45,753	54.01
57.00	05700	CT SCAN	0.053046	1,689,895	89,642	57.00
60.00	06000	LABORATORY	0.120141	4,718,521	566,888	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.623574	174,628	108,893	63.00
65.00	06500	RESPIRATORY THERAPY	0.229179	819,111	187,723	65.00
66.00	06600	PHYSICAL THERAPY	0.250022	567,683	141,933	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.236106	71,209	16,813	67.00
68.00	06800	SPEECH PATHOLOGY	0.295359	32,661	9,647	68.00
69.00	06900	ELECTROCARDIOLOGY	0.068428	1,502,844	102,837	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.161268	2,926	472	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.062836	6,497,808	408,296	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.643649	1,936,308	1,246,303	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.446981	1,868,159	835,032	73.00
76.00	03020	SONOGRAPHY	0.114855	632,208	72,612	76.00
76.01	03040	AUDIOLOGY	0.551061	0	0	76.01
76.02	03160	CARDIAC REHAB	0.310657	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	2.323065	74,286	172,571	90.00
91.00	09100	EMERGENCY	0.347318	1,363,000	473,394	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.572406	185,965	106,447	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		29,041,549	6,279,231	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)		29,041,549		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0143	Period: From 10/01/2017 To 09/30/2018	Worksheet D-3
			Component CCN: 14-U143		Date/Time Prepared: 2/27/2019 1:34 pm
			Title XVIII	Swing Beds - SNF	PPS
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.302990	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.656833	0	52.00
53.00	05300	ANESTHESIOLOGY	0.086204	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.236384	81	54.00
54.01	05402	NUCLEAR MEDICINE	0.298356	0	54.01
57.00	05700	CT SCAN	0.053046	0	57.00
60.00	06000	LABORATORY	0.120141	4,555	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.623574	573	63.00
65.00	06500	RESPIRATORY THERAPY	0.229179	96	65.00
66.00	06600	PHYSICAL THERAPY	0.250022	1,622	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.236106	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.295359	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.068428	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.161268	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.062836	22,812	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.643649	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.446981	4,491	73.00
76.00	03020	SONOGRAPHY	0.114855	0	76.00
76.01	03040	AUDIOLOGY	0.551061	0	76.01
76.02	03160	CARDIAC REHAB	0.310657	0	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
90.00	09000	CLINIC	2.323065	0	90.00
91.00	09100	EMERGENCY	0.347318	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.572406	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		34,230	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)		34,230	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0143	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part A Date/Time Prepared: 2/27/2019 1:34 pm
		Title XVIII	Hospital	PPS
			1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		7,602,211	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)		18,211	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		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		37.01	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		1.81	30.00
31.00	Percentage of Medicaid patient days (see instructions)		13.31	31.00
32.00	Sum of lines 30 and 31		15.12	32.00
33.00	Allowable disproportionate share percentage (see instructions)		2.58	33.00
34.00	Disproportionate share adjustment (see instructions)		49,034	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0143	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part A Date/Time Prepared: 2/27/2019 1:34 pm	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	6,766,695,164	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000032332		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	218,781	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	218,781	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		218,781		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)	7,888,237			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	9,227,861			48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			8,892,955	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			613,244	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)			9,506,199	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			9,506,199	61.00
62.00	Deductibles billed to program beneficiaries			994,864	62.00
63.00	Coinsurance billed to program beneficiaries			9,071	63.00
64.00	Allowable bad debts (see instructions)			149,512	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			97,183	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			89,557	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			8,599,447	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			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)				70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			2,367	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			-1,105	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			17,791	70.93
70.94	HRR adjustment amount (see instructions)			-8,305	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0143	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part A Date/Time Prepared: 2/27/2019 1:34 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		8,610,195	71.00
71.01	Sequestration adjustment (see instructions)		172,204	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		8,605,681	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)		-167,690	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		17,061	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		1,004,718	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)		1.0023561788	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		2,367	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.9989	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		-1,105	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

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet E
Part A Exhibit 5
Date/Time Prepared:
2/27/2019 1:34 pm

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	7,602,211		7,550,645	7,550,645	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	18,211	0	18,211	18,211	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0258	0.0258	0.0258		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	49,034	0	49,034	49,034	11.00
11.01	Uncompensated care payments	36.00	218,781	0	218,781	218,781	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	7,888,237	0	7,888,237	7,888,237	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	9,227,861	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	8,892,955	0	8,892,955	8,892,955	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	613,244	0	613,244	613,244	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			0	9,506,199	9,506,199	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet E
Part A Exhibit 5
Date/Time Prepared:
2/27/2019 1:34 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	610,443	0	610,443	610,443	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	2,801	0	2,801	2,801	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	613,244	0	613,244	613,244	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	17,791	0	17,791	17,791	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	2,367	0	2,367	2,367	30.01
31.00	HRR adjustment (see instructions)	70.94	-8,305	0	-8,305	-8,305	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	-1,105	0	-1,105	-1,105	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0143	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part B Date/Time Prepared: 2/27/2019 1:34 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		43,454	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		12,011,422	2.00
3.00	OPPS payments		8,676,983	3.00
4.00	Outlier payment (see instructions)		106,998	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.799	5.00
6.00	Line 2 times line 5		9,597,126	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		91.53	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)		43,454	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		97,217	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)		97,217	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)		97,217	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		53,763	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)		43,454	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)		8,783,981	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,868,516	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)		6,958,919	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)		6,958,919	30.00
31.00	Primary payer payments		353	31.00
32.00	Subtotal (line 30 minus line 31)		6,958,566	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)		258,813	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		168,228	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		198,499	36.00
37.00	Subtotal (see instructions)		7,126,794	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		7,126,794	40.00
40.01	Sequestration adjustment (see instructions)		142,536	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		6,990,954	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-6,696	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet E-1
Part I
Date/Time Prepared:
2/27/2019 1:34 pm

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		7,851,303		6,990,954	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	09/24/2018	754,378		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)		754,378		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)		8,605,681		6,990,954	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		167,690		6,696	6.02
7.00	Total Medicare program liability (see instructions)		8,437,991		6,984,258	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: 14-0143

Period:

Worksheet E-1

Component CCN: 14-U143

From 10/01/2017
To 09/30/2018Part I
Date/Time Prepared:
2/27/2019 1:34 pm

		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		4,825		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)		4,825		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		41		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		4,866		0	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet E-1
Part II
Date/Time Prepared:
2/27/2019 1:34 pm

Title XVIII

Hospital

PPS

1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-0143 Component CCN: 14-U143	Period: From 10/01/2017 To 09/30/2018	Worksheet E-2 Date/Time Prepared: 2/27/2019 1:34 pm
		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)	6,757	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	15	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)	6,757	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	6,757	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)	6,757	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,834	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)	4,923	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)	64	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	42	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	4,965	0	19.00
19.01	Sequestration adjustment (see instructions)	99	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	4,825	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)	41	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: 14-0143

Period:
From 10/01/2017
To 09/30/2018

Worksheet G

Date/Time Prepared:
2/27/2019 1:34 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	2,900,796	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	17,839,930	0	0	0	4.00
5.00	Other receivable	403,972	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,001,000	0	0	0	6.00
7.00	Inventory	2,121,512	0	0	0	7.00
8.00	Prepaid expenses	662,115	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	19,927,325	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,841,557	0	0	0	12.00
13.00	Land improvements	3,217,398	0	0	0	13.00
14.00	Accumulated depreciation	-2,366,660	0	0	0	14.00
15.00	Buildings	70,245,827	0	0	0	15.00
16.00	Accumulated depreciation	-38,478,706	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	31,955,484	0	0	0	23.00
24.00	Accumulated depreciation	-23,698,135	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	1,128,322	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	44,845,087	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	32,941,161	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	1,684,838	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	34,625,999	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	99,398,411	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	7,764,867	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,369,165	0	0	0	38.00
39.00	Payroll taxes payable	308,257	0	0	0	39.00
40.00	Notes and loans payable (short term)	3,448,165	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	218,696	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	15,109,150	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	22,939,896	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,992,155	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	24,932,051	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	40,041,201	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	59,357,210				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)	59,357,210	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	99,398,411	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018

Worksheet G-1

Date/Time Prepared:
2/27/2019 1:34 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		60,710,331		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,207,545				2.00
3.00	Total (sum of line 1 and line 2)		59,502,786		0		3.00
4.00	CONTRIBUTIONS	101,217		0		0	4.00
5.00	RESTRICTED CONTRIBUTIONS	194,130		0		0	5.00
6.00	DISTRIBUTIONS	8,173		0		0	6.00
7.00	UNRESTRICTED CONTRIBUTIONS	187		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)		303,707		0		10.00
11.00	Subtotal (line 3 plus line 10)		59,806,493		0		11.00
12.00	EQUITY TRANSFER	425,122		0		0	12.00
13.00	CHANGE IN FOUNDATION INTEREST	24,161		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)		449,283		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		59,357,210		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	CONTRIBUTIONS		0				4.00
5.00	RESTRICTED CONTRIBUTIONS		0				5.00
6.00	DISTRIBUTIONS		0				6.00
7.00	UNRESTRICTED CONTRIBUTIONS		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	EQUITY TRANSFER		0				12.00
13.00	CHANGE IN FOUNDATION INTEREST		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: 14-0143

Period:
From 10/01/2017
To 09/30/2018Worksheet G-2
Parts I & II
Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	10,722,445		10,722,445	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)	10,722,445		10,722,445	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,633,480		3,633,480	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)	3,633,480		3,633,480	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	14,355,925		14,355,925	17.00
18.00	Ancillary services	48,063,222	154,024,921	202,088,143	18.00
19.00	Outpatient services	0	29,573,459	29,573,459	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	865,980	865,980	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	4,380,527	4,380,527	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	62,419,147	188,844,887	251,264,034	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		89,510,942		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	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		89,510,942		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0143

Period:
From 10/01/2017
To 09/30/2018

Worksheet G-3

Date/Time Prepared:
2/27/2019 1:34 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	251,264,034	1.00
2.00	Less contractual allowances and discounts on patients' accounts	166,516,715	2.00
3.00	Net patient revenues (line 1 minus line 2)	84,747,319	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	89,510,942	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,763,623	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	229,903	14.00
15.00	Revenue from rental of living quarters	61,999	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	244,614	17.00
18.00	Revenue from sale of medical records and abstracts	1,680	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	152,016	22.00
23.00	Governmental appropriations	0	23.00
24.00	LOSS ON DISPOSAL OF EQUIPMENT	1,506	24.00
24.01	EMR REVENUE	80,001	24.01
24.02	NET RENTAL INCOME	29,382	24.02
24.03	OTHER REVENUE	10,353	24.03
24.04	PARATRANSIT	244,378	24.04
24.05	OUTSIDE REHABILITATION SERVICES	1,056	24.05
24.06	CONTRIBUTIONS SPENT FOR OPERATIONS	90,665	24.06
24.07	INVESTMENT INCOME	2,430,010	24.07
25.00	Total other income (sum of lines 6-24)	3,577,563	25.00
26.00	Total (line 5 plus line 25)	-1,186,060	26.00
27.00	NET RENTAL LOSS	0	27.00
27.01	OTHER	0	27.01
27.02	CHANGE IN EQUITY GAINS AND LOSSES	21,485	27.02
27.03	MISCELLANEOUS	0	27.03
27.04	OTHER EXPENSES (SPECIFY)	0	27.04
27.05	OTHER EXPENSES (SPECIFY)	0	27.05
28.00	Total other expenses (sum of line 27 and subscripts)	21,485	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,207,545	29.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0143

Period:

Worksheet 0

Hospice CCN: 14-1595

From 10/01/2017
To 09/30/2018Date/Time Prepared:
2/27/2019 1:34 pm

		Hospice I				
		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL
		1.00	2.00	3.00	4.00	5.00
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	58,834	58,834	0	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	8,077	8,077	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	24,408	24,408	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	13.00
14.00	PHARMACY*	0	9,002	9,002	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)*	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES					17.00
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	69,618	69,618	0	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	27.00
28.00	REGISTERED NURSE**	472,363	0	472,363	0	28.00
29.00	LPN/LVN**	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	58,014	0	58,014	0	33.00
34.00	SPIRITUAL COUNSELING**	0	0	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	26,924	0	26,924	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	618,303	618,303	0	46.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	71.00
100.00	TOTAL	557,301	788,242	1,345,543	0	100.00

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0143

Period:

Worksheet 0

Hospice CCN: 14-1595

From 10/01/2017
To 09/30/2018Date/Time Prepared:
2/27/2019 1:34 pm

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	Hospice I
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	58,834	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	6.00
7.00	HOUSEKEEPING*	0	0	7.00
8.00	DIETARY*	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	8,077	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	24,408	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	13.00
14.00	PHARMACY*	0	9,002	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)*	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			17.00
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	69,618	26.00
27.00	NURSE PRACTITIONER**	0	0	27.00
28.00	REGISTERED NURSE**	0	472,363	28.00
29.00	LPN/LVN**	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	58,014	33.00
34.00	SPIRITUAL COUNSELING**	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	0	26,924	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	39.00
40.00	IMAGING SERVICES**	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	618,303	46.00
NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	61.00
62.00	FUNDRAISING*	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	66.00
67.00	ADVERTISING*	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	68.00
69.00	THRIFT STORE*	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	71.00
100.00	TOTAL	0	1,345,543	100.00

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE CONTINUOUS HOME CARE

Provider CCN: 14-0143

Period:

Worksheet 0-1

Hospice CCN: 14-1595

From 10/01/2017
To 09/30/2018Date/Time Prepared:
2/27/2019 1:34 pm

				Hospice I		2/27/2018 1:04 pm	
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	0	0	0	0	0	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	0	0	0	0	0	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 50.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	0	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	0	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 50.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE

Provider CCN: 14-0143

Period:

Worksheet 0-2

Hospice CCN: 14-1595

From 10/01/2017
To 09/30/2018Date/Time Prepared:
2/27/2019 1:34 pm

					Hospice I			
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL		
		1.00	2.00	3.00	4.00	5.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS							
25.00	INPATIENT CARE-CONTRACTED						25.00	
26.00	PHYSICIAN SERVICES	0	58,984	58,984	0	58,984	26.00	
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00	
28.00	REGISTERED NURSE	464,364	0	464,364	0	464,364	28.00	
29.00	LPN/LVN	0	0	0	0	0	29.00	
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00	
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00	
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00	
33.00	MEDICAL SOCIAL SERVICES	57,032	0	57,032	0	57,032	33.00	
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00	
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00	
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00	
37.00	HOSPICE AIDE & HOME MAKER SERVICES	26,467	0	26,467	0	26,467	37.00	
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00	
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00	
40.00	IMAGING SERVICES	0	0	0	0	0	40.00	
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00	
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00	
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50	
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00	
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00	
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00	
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	617,287	617,287	0	617,287	46.00	
100.00	TOTAL *	547,863	676,271	1,224,134	0	1,224,134	100.00	

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSICIAN SERVICES	0	58,984	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	464,364	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	57,032	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	26,467	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	617,287	46.00
100.00	TOTAL *	0	1,224,134	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT
RESPIRE CARE

Provider CCN: 14-0143

Period:

Worksheet 0-3

Hospice CCN: 14-1595

From 10/01/2017
To 09/30/2018Date/Time Prepared:
2/27/2019 1:34 pm

				Hospice I			
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	521	521	0	521	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	392	0	392	0	392	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	48	0	48	0	48	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	23	0	23	0	23	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	50	50	0	50	46.00
100.00	TOTAL *	463	571	1,034	0	1,034	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	521	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	392	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	48	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	23	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	50	46.00
100.00	TOTAL *	0	1,034	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL
INPATIENT CARE

Provider CCN: 14-0143

Period:

Worksheet 0-4

Hospice CCN: 14-1595

From 10/01/2017
To 09/30/2018Date/Time Prepared:
2/27/2019 1:34 pm

				Hospice I		2/27/2018 1:04 pm	
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	10,113	10,113	0	10,113	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	7,607	0	7,607	0	7,607	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	934	0	934	0	934	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	434	0	434	0	434	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	966	966	0	966	46.00
100.00	TOTAL *	8,975	11,079	20,054	0	20,054	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	10,113	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	7,607	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	934	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	434	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	966	46.00
100.00	TOTAL *	0	20,054	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET
EXPENSES FOR ALLOCATION

Provider CCN: 14-0143

Period:

Worksheet 0-5

Hospice CCN: 14-1595

From 10/01/2017
To 09/30/2018Date/Time Prepared:
2/27/2019 1:34 pm

Descriptions		Hospice I		TOTAL EXPENSES (sum of cols. 1 + 2)	
		HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)		
		1.00	2.00	3.00	
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	8,588	8,588	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	119,732	119,732	3.00
4.00	ADMINISTRATIVE & GENERAL	58,834	354,596	413,430	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	17,197	17,197	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	8,077	0	8,077	10.00
11.00	MEDICAL RECORDS	0	53,578	53,578	11.00
12.00	STAFF TRANSPORTATION	24,408	0	24,408	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	13.00
14.00	PHARMACY	9,002	0	9,002	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	17.00
LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1,224,134	0	1,224,134	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1,034	0	1,034	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	20,054	0	20,054	53.00
NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	66.00
67.00	ADVERTISING	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	99.00
100.00	TOTAL	1,345,543	553,691	1,899,234	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:

Worksheet 0-6

Hospice CCN: 14-1595

From 10/01/2017
To 09/30/2018Part I
Date/Time Prepared:
2/27/2019 1:34 pm

Descriptions		TOTAL EXPENSES		CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	Hospice I EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A		
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT	8,588	8,588					1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	119,732	0	0	119,732			3.00
4.00	ADMINISTRATIVE & GENERAL	413,430	8,588	0	0	422,018		4.00
5.00	PLANT OPERATION & MAINTENANCE	17,197	0	0	0	17,197		5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0		6.00
7.00	HOUSEKEEPING	0	0	0	0	0		7.00
8.00	DIETARY	0	0	0	0	0		8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	8,077	0	0	0	8,077		10.00
11.00	MEDICAL RECORDS	53,578	0	0	0	53,578		11.00
12.00	STAFF TRANSPORTATION	24,408	0	0	0	24,408		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0		13.00
14.00	PHARMACY	9,002	0	0	0	9,002		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0		15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0	0	0	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	0		17.00
LEVEL OF CARE								
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0		50.00
51.00	HOSPICE ROUTINE HOME CARE	1,224,134			117,705	1,341,839		51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1,034	0	0	99	1,133		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	20,054	0	0	1,928	21,982		53.00
NONREIMBURSABLE COST CENTERS								
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0		60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0		61.00
62.00	FUNDRAISING	0	0	0	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0		66.00
67.00	ADVERTISING	0	0	0	0	0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0		68.00
69.00	THRIFT STORE	0	0	0	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD	0						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0		71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0		99.00
100.00	TOTAL	1,899,234	8,588	0	119,732	1,899,234		100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:

Worksheet 0-6

Hospice CCN: 14-1595

From 10/01/2017
To 09/30/2018Part I
Date/Time Prepared:
2/27/2019 1:34 pm

Descriptions		ADMINISTRATIVE & GENERAL		PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	Hospice I HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00		
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT							1.00
2.00	CAP REL COSTS-MVBLE EQUIP							2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT							3.00
4.00	ADMINISTRATIVE & GENERAL	422,018						4.00
5.00	PLANT OPERATION & MAINTENANCE	4,913	22,110					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0			6.00
7.00	HOUSEKEEPING	0	0			0		7.00
8.00	DIETARY	0	0			0	0	8.00
9.00	NURSING ADMINISTRATION	0	0			0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	2,307	0			0		10.00
11.00	MEDICAL RECORDS	15,306	0			0		11.00
12.00	STAFF TRANSPORTATION	6,973	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0			0		13.00
14.00	PHARMACY	2,572	0			0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0			0		15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0	0			0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0			0		17.00
LEVEL OF CARE								
50.00	HOSPICE CONTINUOUS HOME CARE	0						50.00
51.00	HOSPICE ROUTINE HOME CARE	383,343						51.00
52.00	HOSPICE INPATIENT RESPITE CARE	324	3,904		0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	6,280	18,206		0	0	0	53.00
NONREIMBURSABLE COST CENTERS								
60.00	BEREAVEMENT PROGRAM	0	0			0		60.00
61.00	VOLUNTEER PROGRAM	0	0			0		61.00
62.00	FUNDRAISING	0	0			0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0			0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0			0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0			0		65.00
66.00	RESIDENTIAL CARE	0	0		0	0	0	66.00
67.00	ADVERTISING	0	0			0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0			0		68.00
69.00	THRIFT STORE	0	0			0		69.00
70.00	NURSING FACILITY ROOM & BOARD							70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0		0	0	0	99.00
100.00	TOTAL	422,018	22,110		0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:

Worksheet 0-6

Hospice CCN: 14-1595

From 10/01/2017
To 09/30/2018Part I
Date/Time Prepared:
2/27/2019 1:34 pm

Descriptions		Hospice I					
		NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	10,384				10.00
11.00	MEDICAL RECORDS	0		68,884			11.00
12.00	STAFF TRANSPORTATION	0			31,381		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	10,214	67,754	31,381	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	1	9	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	169	1,121	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	10,384	68,884	31,381	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:

Worksheet 0-6

Hospice CCN: 14-1595

From 10/01/2017
To 09/30/2018Part I
Date/Time Prepared:
2/27/2019 1:34 pm

Descriptions		Hospice I				TOTAL	
		PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE (DELETED)	PATIENT/ RESIDENTIAL CARE SERVICES		
		14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	11,574					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	11,385	0	0		1,845,916	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1	0	0	0	5,372	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	188	0	0	0	47,946	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	11,574	0	0	0	1,899,234	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0143

Period:

Worksheet 0-6

Hospice CCN: 14-1595

From 10/01/2017
To 09/30/2018Part II
Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Descriptions		CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Hospice I RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	974					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	557,301			3.00
4.00	ADMINISTRATIVE & GENERAL	974	0	0	-422,018	1,477,216	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	17,197	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	8,077	10.00
11.00	MEDICAL RECORDS	0	0	0	0	53,578	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	24,408	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	9,002	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			547,863	0	1,341,839	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	463	0	1,133	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	8,975	0	21,982	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	8,588	0	119,732		422,018	100.00
101.00	UNIT COST MULTIPLIER	8.817248	0.000000	0.214843		0.285685	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0143

Period:

Worksheet 0-6

Hospice CCN: 14-1595

From 10/01/2017
To 09/30/2018Part II
Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Descriptions		Hospice I				
		PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)
		5.00	6.00	7.00	8.00	9.00
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE	974				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0			6.00
7.00	HOUSEKEEPING	0		0		7.00
8.00	DIETARY	0		0	0	8.00
9.00	NURSING ADMINISTRATION	0		0		0 9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0 10.00
11.00	MEDICAL RECORDS	0		0		0 11.00
12.00	STAFF TRANSPORTATION	0		0		0 12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0 13.00
14.00	PHARMACY	0		0		0 14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0 15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0		0		0 16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0		0 17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0 50.00
51.00	HOSPICE ROUTINE HOME CARE					0 51.00
52.00	HOSPICE INPATIENT RESPITE CARE	172	0	0	0	0 52.00
53.00	HOSPICE GENERAL INPATIENT CARE	802	0	0	0	0 53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0 60.00
61.00	VOLUNTEER PROGRAM	0		0		0 61.00
62.00	FUNDRAISING	0		0		0 62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0 63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0 64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0 65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0 66.00
67.00	ADVERTISING	0		0		0 67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0 68.00
69.00	THRIFT STORE	0		0		0 69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0 71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	22,110	0	0	0	0 100.00
101.00	UNIT COST MULTIPLIER	22.700205	0.000000	0.000000	0.000000	0.000000 101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0143

Period:

Worksheet 0-6

Hospice CCN: 14-1595

From 10/01/2017
To 09/30/2018Part II
Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Descriptions		Hospice I				
		ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)
		10.00	11.00	12.00	13.00	14.00
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES	7,864				10.00
11.00	MEDICAL RECORDS		7,864			11.00
12.00	STAFF TRANSPORTATION			100		12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0	13.00
14.00	PHARMACY			0	0	7,864 14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0 15.00
16.00	OTHER GENERAL SERVICE (DELETED)			0	0	0 16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES					17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0 50.00
51.00	HOSPICE ROUTINE HOME CARE	7,735	7,735	100	0	7,735 51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1	1	0	0	1 52.00
53.00	HOSPICE GENERAL INPATIENT CARE	128	128	0	0	128 53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0 60.00
61.00	VOLUNTEER PROGRAM			0	0	0 61.00
62.00	FUNDRAISING			0	0	0 62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0 63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0 64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0 65.00
66.00	RESIDENTIAL CARE			0	0	0 66.00
67.00	ADVERTISING			0	0	0 67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0 68.00
69.00	THRIFT STORE			0	0	0 69.00
70.00	NURSING FACILITY ROOM & BOARD			0	0	0 70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0 71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	10,384	68,884	31,381	0	11,574 100.00
101.00	UNIT COST MULTIPLIER	1.320448	8.759410	313.810000	0.000000	1.471770 101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0143

Period:

Worksheet 0-6

Hospice CCN: 14-1595

From 10/01/2017
To 09/30/2018Part II
Date/Time Prepared:
2/27/2019 1:34 pm

Cost Center Descriptions		PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (DELETED) (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)	Hospice I	
		15.00	16.00	17.00		
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				15.00
16.00	OTHER GENERAL SERVICE (DELETED)		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0		53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD		0			70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER		0	0		99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	0	0		100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000		101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY
LEVEL OF CARE

Provider CCN: 14-0143

Period:

Worksheet 0-7

Hospice CCN: 14-1595

From 10/01/2017
To 09/30/2018

Date/Time Prepared:
2/27/2019 1:34 pm

Hospice I

Cost Center Descriptions		From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records)			
				HCHC	HRHC	HIRC	
				2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS	0	1.00	2.00	3.00	4.00	
1.00	PHYSICAL THERAPY	66.00	0.250022	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.236106	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.295359	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.446981	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.120141	0	0	0	6.00
6.01	BLOOD LABORATORY	60.01	0.000000	0	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.062836	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00	0.000000	0	0	0	8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	SONOGRAPHY	76.00	0.114855	0	0	0	10.00
10.01	AUDIOLOGY	76.01	0.551061	0	0	0	10.01
10.02	CARDIAC REHAB	76.02	0.310657	0	0	0	10.02
11.00	Totals (sum of lines 1-11)						11.00
Cost Center Descriptions		Charges by LOC (from Provider Records)	Shared Service Costs by LOC				
		HGIP	HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	0	0	0	0	0	2.00
3.00	SPEECH PATHOLOGY	0	0	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
6.01	BLOOD LABORATORY	0	0	0	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	SONOGRAPHY	0	0	0	0	0	10.00
10.01	AUDIOLOGY	0	0	0	0	0	10.01
10.02	CARDIAC REHAB	0	0	0	0	0	10.02
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 14-0143

Period:

Worksheet 0-8

Hospice CCN: 14-1595

From 10/01/2017
To 09/30/2018Date/Time Prepared:
2/27/2019 1:34 pm

		Hospice I			
		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
HOSPICE CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
HOSPICE ROUTINE HOME CARE					
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, line 11)			1,845,916	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			7,735	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			238.64	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	7,735	0		9.00
10.00	Program cost (line 8 times line 9)	1,845,880	0		10.00
HOSPICE INPATIENT RESPITE CARE					
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11)			5,372	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			1	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			5,372.00	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	1	0		14.00
15.00	Program cost (line 13 times line 14)	5,372	0		15.00
HOSPICE GENERAL INPATIENT CARE					
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11)			47,946	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			128	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			374.58	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	128	0		19.00
20.00	Program cost (line 18 times line 19)	47,946	0		20.00
TOTAL HOSPICE CARE					
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			1,899,234	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			7,864	22.00
23.00	Average cost per diem (line 21 divided by line 22)			241.51	23.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0143	Period: From 10/01/2017 To 09/30/2018	Worksheet L Parts I-III Date/Time Prepared: 2/27/2019 1:34 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		610,443	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		2,801	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)		17.74	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)		613,244	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