

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: 14-0181	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/31/2019 6:55 am
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically filed cost report 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 SOUTH SHORE HOSPITAL CORPORATION (14-0181) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) TIMOTHY CAENEY
 Officer or Administrator of Provider(s)

PRESIDENT/CEO
 Title

(Dated when report is electronically signed.)
 Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-966,794	-58,795	0	0	1.00
2.00	Subprovider - IPF	0	16,782	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-950,012	-58,795	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: 14-0181		Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part I Date/Time Prepared: 5/31/2019 6:55 am		
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 8012 SOUTH CRANDON AVENUE			PO Box:				1.00			
2.00	City: CHICAGO			State: IL		Zip Code: 60617-1175		County: COOK			
		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		SOUTH SHORE HOSPITAL CORPORATION		140181	16974	1	07/01/1966	N	P	P
4.00	Subprovider - IPF		SOUTH SHORE HOSPITAL PSYCH UNIT		14S181	16974	4	01/01/2013	N	P	N
5.00	Subprovider - IRF										
6.00	Subprovider - (Other)										
7.00	Swing Beds - SNF										
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										
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)						01/01/2018		12/31/2018		20.00
21.00	Type of Control (see instructions)						2				21.00
							1.00	2.00		3.00	
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N				22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y				22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N				22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N				23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
				1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			630	240	17	0	3,598	160		24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0181

Period:
From 01/01/2018
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Part I
Date/Time Prepared:
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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.					1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
						Beginning:	Ending:	
						1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
						Y/N	Y/N	
						1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					Y	Y	40.00
						V	XVIII	XIX
						1.00	2.00	3.00
Prospective Payment System (PPS)-Capital								
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	Y	Y
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals								
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
				1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)					N		60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0181

Period:
From 01/01/2018
To 12/31/2018Worksheet S-2
Part I
Date/Time Prepared:
5/31/2019 6:55 am

	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		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010					
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00
			1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS					
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0		71.00
	Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N				75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			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
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
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
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
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00
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.			N	N
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	N
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	N
98.03	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
98.04	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
98.05	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
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	N
Rural Providers					
105.00	Does this hospital qualify as a CAH?			N	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			N	
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	
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	
			Physical	Occupational	Speech
			1.00	2.00	3.00
			Respiratory	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			N	N
				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	

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			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.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	300,000	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y		5.00	122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N			140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0181		Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part I Date/Time Prepared: 5/31/2019 6:55 am	
1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?					Y	144.00
						1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				Y		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N		146.00
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					N	149.00
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.					Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)						168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					9.99	169.00
				Beginning	Ending		
				1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			01/01/2018	12/31/2018	170.00	
				1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)			N		0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0181	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/31/2019 6:55 am
			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)	N		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	06/30/2019
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.	N		15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	05/01/2019	Y
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0181	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/31/2019 6:55 am
		Description	Y/N	Y/N
		0	1.00	3.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N	31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N	33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N	35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?		N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N	40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TONY	LEONE	41.00
42.00	Enter the employer/company name of the cost report preparer.	TONY LEONE, CPA		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	847/275-1023	TONY@LEONE-CONSULTING.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0181	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/31/2019 6:55 am
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CONSULTANT		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: 14-0181

Period:
From 01/01/2018
To 12/31/2018Worksheet S-3
Part I
Date/Time Prepared:
5/31/2019 6:55 am

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	114	41,610	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)		114	41,610	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	2,920	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						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		122	44,530	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	15	5,475		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		137			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0181

Period:
From 01/01/2018
To 12/31/2018Worksheet S-3
Part I
Date/Time Prepared:
5/31/2019 6:55 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	7,142	918	12,712			1.00
2.00	HMO and other (see instructions)	0	3,698				2.00
3.00	HMO IPF Subprovider	0	1,414				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	7,142	918	12,712			7.00
8.00	INTENSIVE CARE UNIT	681	29	1,824			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						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	7,823	947	14,536	0.00	348.10	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,649	164	4,078	0.00	21.92	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	370.02	27.00
28.00	Observation Bed Days		226	3,343			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0181

Period:
From 01/01/2018
To 12/31/2018Worksheet S-3
Part I
Date/Time Prepared:
5/31/2019 6:55 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	836	112	2,284	1.00
2.00 HMO and other (see instructions)			0	585		2.00
3.00 HMO IPF Subprovider				164		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						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	836	112	2,284	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	164	18	417	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0181

Period:
From 01/01/2018
To 12/31/2018Worksheet S-3
Part II
Date/Time Prepared:
5/31/2019 6:55 am

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	18,585,714	0	18,585,714	769,626.00	24.15
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		1,370,512	69,649	1,440,161	65,117.00	22.12
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,870,636	0	2,870,636	27,913.00	102.84
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		380,903	0	380,903	2,520.00	151.15
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		3,106,403	0	3,106,403		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		260,926	0	260,926		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	256,222	0	256,222	8,376.00	30.59
27.00	Administrative & General	5.00	2,959,511	-69,649	2,889,862	114,781.00	25.18

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0181

Period:
From 01/01/2018
To 12/31/2018Worksheet S-3
Part II
Date/Time Prepared:
5/31/2019 6:55 am

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		314,539	0	314,539	6,095.00	51.61	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	727,043	0	727,043	40,591.00	17.91	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	530,022	0	530,022	42,383.00	12.51	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	627,165	0	627,165	42,599.00	14.72	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	9,773	0	9,773	1,015.00	9.63	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	789,870	0	789,870	19,161.00	41.22	38.00
39.00	Central Services and Supply	14.00	82,167	0	82,167	6,357.00	12.93	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	443,668	0	443,668	22,077.00	20.10	41.00
42.00	Social Service	17.00	76,770	0	76,770	3,867.00	19.85	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0181

Period:
From 01/01/2018
To 12/31/2018Worksheet S-3
Part III
Date/Time Prepared:
5/31/2019 6:55 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	18,900,253	0	18,900,253	775,721.00	24.36	1.00
2.00	Excluded area salaries (see instructions)	1,370,512	69,649	1,440,161	65,117.00	22.12	2.00
3.00	Subtotal salaries (line 1 minus line 2)	17,529,741	-69,649	17,460,092	710,604.00	24.57	3.00
4.00	Subtotal other wages & related costs (see inst.)	3,251,539	0	3,251,539	30,433.00	106.84	4.00
5.00	Subtotal wage-related costs (see inst.)	3,106,403	0	3,106,403	0.00	17.79	5.00
6.00	Total (sum of lines 3 thru 5)	23,887,683	-69,649	23,818,034	741,037.00	32.14	6.00
7.00	Total overhead cost (see instructions)	6,816,750	-69,649	6,747,101	307,302.00	21.96	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0181

Period:
From 01/01/2018
To 12/31/2018Worksheet S-3
Part IV
Date/Time Prepared:
5/31/2019 6:55 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	196,278	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)	1,283,828	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	33,698	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	19,831	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	120,848	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	212,261	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	1,399,040	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	51,000	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	50,545	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	3,367,329	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: 14-0181

Period:
From 01/01/2018
To 12/31/2018Worksheet S-3
Part V
Date/Time Prepared:
5/31/2019 6:55 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	2,870,636	3,367,329	1.00
2.00	Hospital	2,870,636	3,106,403	2.00
3.00	Subprovider - IPF	0	220,203	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	40,723	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0181

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

Worksheet S-10

Date/Time Prepared:
5/31/2019 6:55 am

				1.00	
	Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.368335	1.00
	Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			10,893,694	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			44,907,242	6.00
7.00	Medicaid cost (line 1 times line 6)			16,540,909	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)			5,647,215	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP			0	9.00
10.00	Stand-alone CHIP charges			0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00
	Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			5,647,215	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)	3,175,194	449,003	3,624,197	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,169,535	449,003	1,618,538	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,169,535	449,003	1,618,538	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)			631,091	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			161,884	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			249,052	27.01
28.00	Non-Medicare bad debt expense (see instructions)			382,039	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			227,886	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			1,846,424	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			7,493,639	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0181

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

Worksheet A

Date/Time Prepared:
5/31/2019 6:55 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,085,661	1,085,661	-599,390	486,271	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	599,390	599,390	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	256,222	2,945,891	3,202,113	-763,594	2,438,519	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,959,511	5,318,766	8,278,277	684,462	8,962,739	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	727,043	845,020	1,572,063	0	1,572,063	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	26,402	26,402	8.00
9.00	00900	HOUSEKEEPING	530,022	175,759	705,781	-26,402	679,379	9.00
10.00	01000	DIETARY	627,165	383,940	1,011,105	0	1,011,105	10.00
11.00	01100	CAFETERIA	9,773	196,757	206,530	0	206,530	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	789,870	110,907	900,777	0	900,777	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	82,167	341,197	423,364	-308,065	115,299	14.00
15.00	01500	PHARMACY	0	3,332,875	3,332,875	-637,708	2,695,167	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	443,668	314,940	758,608	0	758,608	16.00
17.00	01700	SOCIAL SERVICE	76,770	34,703	111,473	0	111,473	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,121,029	1,257,351	6,378,380	-7,741	6,370,639	30.00
31.00	03100	INTENSIVE CARE UNIT	1,138,019	242,084	1,380,103	-6,988	1,373,115	31.00
40.00	04000	SUBPROVIDER - IPF	1,156,616	875,894	2,032,510	-2,897	2,029,613	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	495,267	425,562	920,829	-227,801	693,028	50.00
51.00	05100	RECOVERY ROOM	195,276	20,755	216,031	-1,073	214,958	51.00
53.00	05300	ANESTHESIOLOGY	36,282	567,001	603,283	-11,631	591,652	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	532,674	626,231	1,158,905	-2,773	1,156,132	54.00
54.01	03630	ULTRA SOUND	160,903	22,192	183,095	-470	182,625	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	131,077	131,077	-17,458	113,619	57.00
58.00	05800	MRI	0	34,125	34,125	-525	33,600	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	753,704	1,024,452	1,778,156	0	1,778,156	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	41,848	231,999	273,847	-31,217	242,630	63.00
65.00	06500	RESPIRATORY THERAPY	439,906	248,056	687,962	-36,024	651,938	65.00
66.00	06600	PHYSICAL THERAPY	143,887	50,943	194,830	-910	193,920	66.00
68.00	06800	SPEECH PATHOLOGY	0	22,703	22,703	0	22,703	68.00
69.00	06900	ELECTROCARDIOLOGY	137,997	182,784	320,781	-6,333	314,448	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	815,259	815,259	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,271	10,271	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	542,345	542,345	73.00
74.00	07400	RENAL DIALYSIS	0	331,293	331,293	0	331,293	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	41,059	41,059	-11,911	29,148	90.01
91.00	09100	EMERGENCY	1,516,199	1,315,179	2,831,378	-56,350	2,775,028	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,371,818	22,737,156	41,108,974	-79,132	41,029,842	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	213,896	166,847	380,743	0	380,743	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND RAISING	0	0	0	25,656	25,656	194.01
194.02	07952	MARKETING OTHER	0	0	0	53,476	53,476	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	18,585,714	22,904,003	41,489,717	0	41,489,717	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0181

Period:
From 01/01/2018
To 12/31/2018Worksheet A
Date/Time Prepared:
5/31/2019 6:55 am

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	486,271	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	599,390	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,438,519	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-264,668	8,698,071	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-53,685	1,518,378	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	26,402	8.00
9.00	00900	HOUSEKEEPING	0	679,379	9.00
10.00	01000	DIETARY	0	1,011,105	10.00
11.00	01100	CAFETERIA	-124,716	81,814	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	900,777	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-9,161	106,138	14.00
15.00	01500	PHARMACY	0	2,695,167	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-20,760	737,848	16.00
17.00	01700	SOCIAL SERVICE	0	111,473	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-554,827	5,815,812	30.00
31.00	03100	INTENSIVE CARE UNIT	-51,835	1,321,280	31.00
40.00	04000	SUBPROVIDER - IPF	-209,868	1,819,745	40.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-20,021	673,007	50.00
51.00	05100	RECOVERY ROOM	0	214,958	51.00
53.00	05300	ANESTHESIOLOGY	-550,450	41,202	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-14,847	1,141,285	54.00
54.01	03630	ULTRA SOUND	0	182,625	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	113,619	57.00
58.00	05800	MRI	0	33,600	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-193,232	1,584,924	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	242,630	63.00
65.00	06500	RESPIRATORY THERAPY	-12,663	639,275	65.00
66.00	06600	PHYSICAL THERAPY	0	193,920	66.00
68.00	06800	SPEECH PATHOLOGY	0	22,703	68.00
69.00	06900	ELECTROCARDIOLOGY	-142,522	171,926	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	815,259	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,271	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	542,345	73.00
74.00	07400	RENAL DIALYSIS	0	331,293	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.01	09001	WOUND CARE	-29,000	148	90.01
91.00	09100	EMERGENCY	-811,236	1,963,792	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,063,491	37,966,351	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	0	380,743	192.01
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	07951	FUND RAISING	0	25,656	194.01
194.02	07952	MARKETING OTHER	0	53,476	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,063,491	38,426,226	200.00

RECLASSIFICATIONS

Provider CCN: 14-0181

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

Worksheet A-6

Date/Time Prepared:
5/31/2019 6:55 am

Increases					
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - MEDICAL SUPPLIES SOLD TO PATIENTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	825,530	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
20.00		0.00	0	0	20.00
TOTALS			0	825,530	
B - FUNDRAISING					
1.00	FUND RAISING	194.01	23,833	1,823	1.00
TOTALS			23,833	1,823	
C - MARKETING					
1.00	MARKETING OTHER	194.02	45,816	7,660	1.00
TOTALS			45,816	7,660	
D - NON BENEFITS TO A & G					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	763,594	1.00
TOTALS			0	763,594	
E - DRUGS CHARGED T					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	542,345	1.00
TOTALS			0	542,345	
F - COST OF IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	10,271	1.00
TOTALS			0	10,271	
G - LAUNDRY COSTS					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	26,402	1.00
TOTALS			0	26,402	
H - DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	599,390	1.00
TOTALS			0	599,390	
500.00	Grand Total: Increases		69,649	2,777,015	500.00

RECLASSIFICATIONS

Provider CCN: 14-0181

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

Worksheet A-6

Date/Time Prepared:
5/31/2019 6:55 am

	Decreases				Wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other		
	6.00	7.00	8.00	9.00	10.00	
	A - MEDICAL SUPPLIES SOLD TO PATIENTS					
1.00	CENTRAL SERVICES & SUPPLY	14.00		308,065	0	1.00
2.00	PHARMACY	15.00		95,363	0	2.00
3.00	ADULTS & PEDIATRICS	30.00		7,741	0	3.00
4.00	INTENSIVE CARE UNIT	31.00		6,988	0	4.00
5.00	SUBPROVIDER - IPF	40.00		2,897	0	5.00
6.00	OPERATING ROOM	50.00		227,801	0	6.00
7.00	RECOVERY ROOM	51.00		1,073	0	7.00
8.00	ANESTHESIOLOGY	53.00		11,631	0	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00		2,773	0	9.00
10.00	ULTRA SOUND	54.01		470	0	10.00
11.00	CT SCAN	57.00		17,458	0	11.00
12.00	MRI	58.00		525	0	12.00
13.00	BLOOD STORING, PROCESSING & TRANS.	63.00		31,217	0	13.00
14.00	RESPIRATORY THERAPY	65.00		36,024	0	14.00
15.00	PHYSICAL THERAPY	66.00		910	0	15.00
16.00	ELECTROCARDIOLOGY	69.00		6,333	0	16.00
17.00	WOUND CARE	90.01		11,911	0	17.00
18.00	EMERGENCY	91.00		56,350	0	18.00
20.00	EMERGENCY				0	20.00
	TOTALS		0	825,530		
	B - FUNDRAISING					
1.00	ADMINISTRATIVE & GENERAL	5.00	23,833	1,823	0	1.00
	TOTALS		23,833	1,823		
	C - MARKETING					
1.00	ADMINISTRATIVE & GENERAL	5.00	45,816	7,660	0	1.00
	TOTALS		45,816	7,660		
	D - NON BENEFITS TO A & G					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	763,594	0	1.00
	TOTALS		0	763,594		
	E - DRUGS CHARGED T					
1.00	PHARMACY	15.00	0	542,345	0	1.00
	TOTALS		0	542,345		
	F - COST OF IMPLANTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	10,271	0	1.00
	TOTALS		0	10,271		
	G - LAUNDRY COSTS					
1.00	HOUSEKEEPING	9.00	0	26,402	0	1.00
	TOTALS		0	26,402		
	H - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	599,390	9	1.00
	TOTALS		0	599,390		
500.00	Grand Total: Decreases		69,649	2,777,015		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0181

Period:
From 01/01/2018
To 12/31/2018Worksheet A-7
Part I
Date/Time Prepared:
5/31/2019 6:55 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,474,845	0	0	0	46,267	1.00	
2.00	Land Improvements	1,100,274	0	0	0	0	2.00	
3.00	Buildings and Fixtures	17,790,291	0	0	0	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	10,770,913	0	0	0	0	5.00	
6.00	Movable Equipment	21,992,570	0	0	0	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	53,128,893	0	0	0	46,267	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	53,128,893	0	0	0	46,267	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,428,578	0					1.00
2.00	Land Improvements	1,100,274	0					2.00
3.00	Buildings and Fixtures	17,790,291	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	10,770,913	0					5.00
6.00	Movable Equipment	21,992,570	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	53,082,626	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	53,082,626	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0181

Period:
From 01/01/2018
To 12/31/2018Worksheet A-7
Part II
Date/Time Prepared:
5/31/2019 6:55 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,085,661	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,085,661	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,085,661				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	1,085,661				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0181

Period:
From 01/01/2018
To 12/31/2018Worksheet A-7
Part III
Date/Time Prepared:
5/31/2019 6:55 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	31,090,057	0	31,090,057	0.585692	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	21,992,569	0	21,992,569	0.414308	0	2.00
3.00	Total (sum of lines 1-2)	53,082,626	0	53,082,626	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	486,271	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	599,390	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,085,661	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	CAP REL COSTS-BLDG & FIXT	0	0	0	0	486,271	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	599,390	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,085,661	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0181

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

Worksheet A-8

Date/Time Prepared:
5/31/2019 6:55 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-9,161	CENTRAL SERVICES & SUPPLY	14.00	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)	A	-36,465	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,643,501			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-124,716	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others	B	-53,685	OPERATION OF PLANT	7.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-20,760	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	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OFFSET A & G MISC INCOME	B	-105,820	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0181

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

Worksheet A-8

Date/Time Prepared:
5/31/2019 6:55 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.01	PHYSICIAN PRO FEE	A	0	PHYSICIANS' PRIVATE OFFICES-CLINICS	192.01	0	33.01
34.00	LOBBY EXPENSE	A	-19,383	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	LOBBYIEST EXPENSE	A	-50,000	ADMINISTRATIVE & GENERAL	5.00	0	34.01
35.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,063,491				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0181

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

Worksheet A-8-2

Date/Time Prepared:
5/31/2019 6:55 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	554,827	554,827	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	51,835	51,835	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	209,868	209,868	0	0	0	3.00
4.00	50.00	OPERATING ROOM	95,362	0	95,362	246,400	636	4.00
5.00	53.00	ANESTHESIOLOGY	550,450	550,450	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	44,913	10,455	34,458	271,900	230	6.00
7.00	60.00	LABORATORY	193,232	193,232	0	0	0	7.00
8.00	65.00	RESPIRATORY THERAPY	33,000	0	33,000	211,500	200	8.00
9.00	69.00	ELECTROCARDIOLOGY	142,522	142,522	0	0	0	9.00
10.00	90.01	WOUND CARE	29,000	29,000	0	0	0	10.00
11.00	91.00	EMERGENCY	959,083	741,000	218,083	211,500	1,454	11.00
12.00	5.00	ADMINISTRATIVE & GENERAL	53,000	53,000	0	0	0	12.00
200.00			2,917,092	2,536,189	380,903		2,520	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	75,341	3,767	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	30,066	1,503	0	0	0	6.00
7.00	60.00	LABORATORY	0	0	0	0	0	7.00
8.00	65.00	RESPIRATORY THERAPY	20,337	1,017	0	0	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	9.00
10.00	90.01	WOUND CARE	0	0	0	0	0	10.00
11.00	91.00	EMERGENCY	147,847	7,392	0	0	0	11.00
12.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	12.00
200.00			273,591	13,679	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	554,827		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	51,835		2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	209,868		3.00
4.00	50.00	OPERATING ROOM	0	75,341	20,021	20,021		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	550,450		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	30,066	4,392	14,847		6.00
7.00	60.00	LABORATORY	0	0	0	193,232		7.00
8.00	65.00	RESPIRATORY THERAPY	0	20,337	12,663	12,663		8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	142,522		9.00
10.00	90.01	WOUND CARE	0	0	0	29,000		10.00
11.00	91.00	EMERGENCY	0	147,847	70,236	811,236		11.00
12.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	53,000		12.00
200.00			0	273,591	107,312	2,643,501		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0181

Period:
From 01/01/2018
To 12/31/2018Worksheet B
Part I
Date/Time Prepared:
5/31/2019 6:55 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	486,271	486,271			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	599,390		599,390		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,438,519	1,202	983	2,440,704	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,698,071	48,946	296,001	384,805	9,427,823
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,518,378	34,917	3,100	96,811	1,653,206
8.00	00800	LAUNDRY & LINEN SERVICE	26,402	3,497	0	0	29,899
9.00	00900	HOUSEKEEPING	679,379	11,211	0	70,576	761,166
10.00	01000	DIETARY	1,011,105	10,692	999	83,511	1,106,307
11.00	01100	CAFETERIA	81,814	9,913	738	1,301	93,766
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	900,777	4,127	14,089	105,177	1,024,170
14.00	01400	CENTRAL SERVICES & SUPPLY	106,138	6,201	2,054	10,941	125,334
15.00	01500	PHARMACY	2,695,167	5,918	243	0	2,701,328
16.00	01600	MEDICAL RECORDS & LIBRARY	737,848	2,289	1,779	59,077	800,993
17.00	01700	SOCIAL SERVICE	111,473	490	0	10,222	122,185
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,815,812	168,835	41,300	681,906	6,707,853
31.00	03100	INTENSIVE CARE UNIT	1,321,280	15,073	19,041	151,535	1,506,929
40.00	04000	SUBPROVIDER - IPF	1,819,745	34,244	21,019	154,012	2,029,020
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	673,007	31,409	66,402	65,948	836,766
51.00	05100	RECOVERY ROOM	214,958	2,217	2,378	26,002	245,555
53.00	05300	ANESTHESIOLOGY	41,202	1,480	22,972	4,831	70,485
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,141,285	20,838	35,248	70,929	1,268,300
54.01	03630	ULTRA SOUND	182,625	1,144	16,680	21,425	221,874
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	113,619	2,106	0	0	115,725
58.00	05800	MRI	33,600	0	0	0	33,600
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	1,584,924	15,020	5,577	100,361	1,705,882
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	242,630	1,109	1,514	5,572	250,825
65.00	06500	RESPIRATORY THERAPY	639,275	8,904	17,755	58,577	724,511
66.00	06600	PHYSICAL THERAPY	193,920	11,429	1,788	19,160	226,297
68.00	06800	SPEECH PATHOLOGY	22,703	0	3,292	0	25,995
69.00	06900	ELECTROCARDIOLOGY	171,926	5,160	17,372	18,375	212,833
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	815,259	0	0	0	815,259
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,271	0	0	0	10,271
73.00	07300	DRUGS CHARGED TO PATIENTS	542,345	0	0	0	542,345
74.00	07400	RENAL DIALYSIS	331,293	1,019	0	0	332,312
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOUND CARE	148	1,030	0	0	1,178
91.00	09100	EMERGENCY	1,963,792	25,422	2,856	201,893	2,193,963
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	37,966,351	485,842	595,180	2,402,947	37,923,955
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		429	0	0	429
192.01	19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	380,743	0	4,210	28,482	413,435
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	FUND RAISING	25,656	0	0	3,174	28,830
194.02	07952	MARKETING OTHER	53,476	0	0	6,101	59,577
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers					0
202.00		TOTAL (sum lines 118 through 201)	38,426,226	486,271	599,390	2,440,704	38,426,226

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0181

Period:
From 01/01/2018
To 12/31/2018Worksheet B
Part I
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,427,823					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	537,482	0	2,190,688			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,721	0	19,097	58,717		8.00
9.00	00900	HOUSEKEEPING	247,466	0	61,215	4,401	1,074,248	9.00
10.00	01000	DIETARY	359,677	0	58,383	0	0	10.00
11.00	01100	CAFETERIA	30,485	0	54,127	0	15,024	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	332,973	0	22,533	0	7,512	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	40,748	0	33,859	347	30,049	14.00
15.00	01500	PHARMACY	878,242	0	32,316	0	15,024	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	260,415	0	12,497	0	33,805	16.00
17.00	01700	SOCIAL SERVICE	39,724	0	2,675	0	3,756	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,180,832	0	921,874	37,021	394,393	30.00
31.00	03100	INTENSIVE CARE UNIT	489,925	0	82,303	6,276	90,147	31.00
40.00	04000	SUBPROVIDER - IPF	659,665	0	186,983	2,559	0	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	272,045	0	171,499	1,836	120,196	50.00
51.00	05100	RECOVERY ROOM	79,834	0	12,106	376	15,024	51.00
53.00	05300	ANESTHESIOLOGY	22,916	0	8,084	0	82,634	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	412,343	0	113,779	778	0	54.00
54.01	03630	ULTRA SOUND	72,135	0	6,248	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	37,624	0	11,501	0	7,512	57.00
58.00	05800	MRI	10,924	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	554,608	0	82,010	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	81,547	0	6,053	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	235,549	0	48,620	0	18,781	65.00
66.00	06600	PHYSICAL THERAPY	73,573	0	62,406	1,206	18,781	66.00
68.00	06800	SPEECH PATHOLOGY	8,451	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	69,195	0	28,176	1,332	33,805	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	265,053	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,339	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	176,324	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	108,040	0	5,565	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	383	0	5,624	0	0	90.01
91.00	09100	EMERGENCY	713,290	0	138,812	2,585	165,269	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,264,528	0	2,188,345	58,717	1,051,712	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	139	0	2,343	0	15,024	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	134,414	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND RAISING	9,373	0	0	0	3,756	194.01
194.02	07952	MARKETING OTHER	19,369	0	0	0	3,756	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	9,427,823	0	2,190,688	58,717	1,074,248	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0181

Period:
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,524,367					10.00
11.00	01100	CAFETERIA	0	193,402				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	7,127	0	1,394,315		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,368	0	0	232,705	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,210	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,439	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,147,792	73,679	0	782,771	0	30.00
31.00	03100	INTENSIVE CARE UNIT	68,660	12,551	0	133,301	0	31.00
40.00	04000	SUBPROVIDER - IPF	307,915	16,962	0	180,166	0	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	7,227	0	76,796	0	50.00
51.00	05100	RECOVERY ROOM	0	1,973	0	21,002	0	51.00
53.00	05300	ANESTHESIOLOGY	0	627	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,902	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	1,633	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	15,623	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	751	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	7,173	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,548	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,600	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	221,279	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	11,426	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	18,850	0	200,279	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,524,367	187,243	0	1,394,315	232,705	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	0	6,159	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND RAISING	0	0	0	0	0	194.01
194.02	07952	MARKETING OTHER	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,524,367	193,402	0	1,394,315	232,705	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0181

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	3,626,910					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,115,920				16.00
17.00	01700	SOCIAL SERVICE	0	0	169,779			17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	632,403	109,825	12,988,443	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	68,521	11,890	2,470,503	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	134,208	23,318	3,540,796	0	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	68,070	20,419	1,574,854	0	50.00
51.00	05100	RECOVERY ROOM	0	0	4,327	380,197	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	184,746	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	1,802,102	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	301,890	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	172,362	0	57.00
58.00	05800	MRI	0	0	0	44,524	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	2,358,123	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	339,176	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,034,634	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	383,811	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	34,446	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	347,941	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,301,591	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	25,036	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,618,071	0	0	4,336,740	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	445,917	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	7,185	0	90.01
91.00	09100	EMERGENCY	0	212,718	0	3,645,766	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,618,071	1,115,920	169,779	37,720,783	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	17,935	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	8,839	0	0	562,847	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND RAISING	0	0	0	41,959	0	194.01
194.02	07952	MARKETING OTHER	0	0	0	82,702	0	194.02
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)	3,626,910	1,115,920	169,779	38,426,226	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0181

Period:
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To 12/31/2018Worksheet B
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	03630	ULTRA SOUND	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	63.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
90.01	09001	WOUND CARE	90.01
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
191.00	19100	RESEARCH	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	192.01
193.00	19300	NONPAID WORKERS	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	194.00
194.01	07951	FUND RAISING	194.01
194.02	07952	MARKETING OTHER	194.02
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0181

Period:
From 01/01/2018
To 12/31/2018Worksheet B
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,202	983	2,185	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	48,946	296,001	344,947	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	34,917	3,100	38,017	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,497	0	3,497	8.00
9.00	00900	HOUSEKEEPING	0	11,211	0	11,211	9.00
10.00	01000	DIETARY	0	10,692	999	11,691	10.00
11.00	01100	CAFETERIA	0	9,913	738	10,651	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	4,127	14,089	18,216	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,201	2,054	8,255	14.00
15.00	01500	PHARMACY	0	5,918	243	6,161	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,289	1,779	4,068	16.00
17.00	01700	SOCIAL SERVICE	0	490	0	490	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	168,835	41,300	210,135	30.00
31.00	03100	INTENSIVE CARE UNIT	0	15,073	19,041	34,114	31.00
40.00	04000	SUBPROVIDER - IPF	0	34,244	21,019	55,263	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	31,409	66,402	97,811	50.00
51.00	05100	RECOVERY ROOM	0	2,217	2,378	4,595	51.00
53.00	05300	ANESTHESIOLOGY	0	1,480	22,972	24,452	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	20,838	35,248	56,086	54.00
54.01	03630	ULTRA SOUND	0	1,144	16,680	17,824	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	2,106	0	2,106	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	15,020	5,577	20,597	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,109	1,514	2,623	63.00
65.00	06500	RESPIRATORY THERAPY	0	8,904	17,755	26,659	65.00
66.00	06600	PHYSICAL THERAPY	0	11,429	1,788	13,217	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	3,292	3,292	68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,160	17,372	22,532	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	1,019	0	1,019	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	1,030	0	1,030	90.01
91.00	09100	EMERGENCY	0	25,422	2,856	28,278	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	485,842	595,180	1,081,022	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	429	0	429	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	0	0	4,210	4,210	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	FUND RAISING	0	0	0	0	194.01
194.02	07952	MARKETING OTHER	0	0	0	0	194.02
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	486,271	599,390	1,085,661	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0181

Period:
From 01/01/2018
To 12/31/2018Worksheet B
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	345,291					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	19,685	0	57,789			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	356		504	4,357		8.00
9.00	00900	HOUSEKEEPING	9,063	0	1,615	327	22,279	9.00
10.00	01000	DIETARY	13,173	0	1,540	0	0	10.00
11.00	01100	CAFETERIA	1,116	0	1,428	0	312	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	12,195	0	594	0	156	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,492	0	893	26	623	14.00
15.00	01500	PHARMACY	32,165	0	852	0	312	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,537	0	330	0	701	16.00
17.00	01700	SOCIAL SERVICE	1,455	0	71	0	78	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	79,876	0	24,319	2,746	8,177	30.00
31.00	03100	INTENSIVE CARE UNIT	17,943	0	2,171	466	1,870	31.00
40.00	04000	SUBPROVIDER - IPF	24,160	0	4,933	190	0	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,963	0	4,524	136	2,493	50.00
51.00	05100	RECOVERY ROOM	2,924	0	319	28	312	51.00
53.00	05300	ANESTHESIOLOGY	839	0	213	0	1,714	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,102	0	3,001	58	0	54.00
54.01	03630	ULTRA SOUND	2,642	0	165	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	1,378	0	303	0	156	57.00
58.00	05800	MRI	400	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	20,312	0	2,163	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,987	0	160	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	8,627	0	1,283	0	389	65.00
66.00	06600	PHYSICAL THERAPY	2,695	0	1,646	89	389	66.00
68.00	06800	SPEECH PATHOLOGY	310	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,534	0	743	99	701	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,707	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	122	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,458	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	3,957	0	147	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	14	0	148	0	0	90.01
91.00	09100	EMERGENCY	26,124	0	3,662	192	3,428	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	339,311	0	57,727	4,357	21,811	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5	0	62	0	312	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	4,923	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND RAISING	343	0	0	0	78	194.01
194.02	07952	MARKETING OTHER	709	0	0	0	78	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	345,291	0	57,789	4,357	22,279	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0181

Period:
From 01/01/2018
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	26,479					10.00
11.00	01100	CAFETERIA	0	13,508				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	498	0	31,753		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	165	0	0	11,464	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	573	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	101	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	19,937	5,145	0	17,826	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,193	877	0	3,036	0	31.00
40.00	04000	SUBPROVIDER - IPF	5,349	1,185	0	4,103	0	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	505	0	1,749	0	50.00
51.00	05100	RECOVERY ROOM	0	138	0	478	0	51.00
53.00	05300	ANESTHESIOLOGY	0	44	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	482	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	114	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	1,091	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	52	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	501	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	108	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	182	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	10,901	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	563	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	1,317	0	4,561	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,479	13,078	0	31,753	11,464	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	0	430	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND RAISING	0	0	0	0	0	194.01
194.02	07952	MARKETING OTHER	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	26,479	13,508	0	31,753	11,464	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0181

Period:
From 01/01/2018
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Part II
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	39,490					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	15,262				16.00
17.00	01700	SOCIAL SERVICE	0	0	2,204			17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	8,649	1,426	378,851	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	937	154	62,896	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	1,836	303	97,460	0	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	931	265	118,436	0	50.00
51.00	05100	RECOVERY ROOM	0	0	56	8,873	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	27,266	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	74,792	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	20,764	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	3,943	0	57.00
58.00	05800	MRI	0	0	0	400	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	44,253	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	5,827	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	37,511	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	18,161	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,602	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	26,807	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	20,608	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	685	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,394	0	0	45,852	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	5,123	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	1,192	0	90.01
91.00	09100	EMERGENCY	0	2,909	0	70,651	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	39,394	15,262	2,204	1,073,953	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	808	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	96	0	0	9,684	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND RAISING	0	0	0	424	0	194.01
194.02	07952	MARKETING OTHER	0	0	0	792	0	194.02
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	39,490	15,262	2,204	1,085,661	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0181

Period:
From 01/01/2018
To 12/31/2018Worksheet B
Part II
Date/Time Prepared:
5/31/2019 6:55 am

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	03630	ULTRA SOUND	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	63.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
90.01	09001	WOUND CARE	90.01
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
191.00	19100	RESEARCH	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	192.01
193.00	19300	NONPAID WORKERS	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	194.00
194.01	07951	FUND RAISING	194.01
194.02	07952	MARKETING OTHER	194.02
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0181

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

Worksheet B-1

Date/Time Prepared:
5/31/2019 6:55 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	135,979					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		596,384				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	336	978	18,329,492			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,687	294,517	2,889,862	-9,427,823	28,998,403	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	9,764	3,084	727,043	0	1,653,206	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	978	0	0	0	29,899	8.00
9.00	00900	HOUSEKEEPING	3,135	0	530,022	0	761,166	9.00
10.00	01000	DIETARY	2,990	994	627,165	0	1,106,307	10.00
11.00	01100	CAFETERIA	2,772	734	9,773	0	93,766	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,154	14,018	789,870	0	1,024,170	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,734	2,044	82,167	0	125,334	14.00
15.00	01500	PHARMACY	1,655	242	0	0	2,701,328	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	640	1,770	443,668	0	800,993	16.00
17.00	01700	SOCIAL SERVICE	137	0	76,770	0	122,185	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	47,212	41,093	5,121,029	0	6,707,853	30.00
31.00	03100	INTENSIVE CARE UNIT	4,215	18,946	1,138,019	0	1,506,929	31.00
40.00	04000	SUBPROVIDER - IPF	9,576	20,914	1,156,616	0	2,029,020	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,783	66,069	495,267	0	836,766	50.00
51.00	05100	RECOVERY ROOM	620	2,366	195,276	0	245,555	51.00
53.00	05300	ANESTHESIOLOGY	414	22,857	36,282	0	70,485	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,827	35,071	532,674	0	1,268,300	54.00
54.01	03630	ULTRA SOUND	320	16,596	160,903	0	221,874	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	589	0	0	0	115,725	57.00
58.00	05800	MRI	0	0	0	0	33,600	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	4,200	5,549	753,704	0	1,705,882	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	310	1,506	41,848	0	250,825	63.00
65.00	06500	RESPIRATORY THERAPY	2,490	17,666	439,906	0	724,511	65.00
66.00	06600	PHYSICAL THERAPY	3,196	1,779	143,887	0	226,297	66.00
68.00	06800	SPEECH PATHOLOGY	0	3,275	0	0	25,995	68.00
69.00	06900	ELECTROCARDIOLOGY	1,443	17,285	137,997	0	212,833	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	815,259	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	10,271	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	542,345	73.00
74.00	07400	RENAL DIALYSIS	285	0	0	0	332,312	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	288	0	0	0	1,178	90.01
91.00	09100	EMERGENCY	7,109	2,842	1,516,199	0	2,193,963	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	135,859	592,195	18,045,947	-9,427,823	28,496,132	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	120	0	0	0	429	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	0	4,189	213,896	0	413,435	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND RAISING	0	0	23,833	0	28,830	194.01
194.02	07952	MARKETING OTHER	0	0	45,816	0	59,577	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	486,271	599,390	2,440,704		9,427,823	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.576074	1.005040	0.133157		0.325115	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			2,185		345,291	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000119		0.011907	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0181

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

Worksheet B-1

Date/Time Prepared:
5/31/2019 6:55 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
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: 14-0181

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

Worksheet B-1

Date/Time Prepared:
5/31/2019 6:55 am

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVIC)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	112,192				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	978	466,474			8.00
9.00	00900	HOUSEKEEPING	0	3,135	34,967	7,150		9.00
10.00	01000	DIETARY	0	2,990	0	0	60,744	10.00
11.00	01100	CAFETERIA	0	2,772	0	100	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,154	0	50	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,734	2,754	200	0	14.00
15.00	01500	PHARMACY	0	1,655	0	100	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	640	0	225	0	16.00
17.00	01700	SOCIAL SERVICE	0	137	0	25	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	47,212	294,107	2,625	45,738	30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,215	49,860	600	2,736	31.00
40.00	04000	SUBPROVIDER - IPF	0	9,576	20,333	0	12,270	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	8,783	14,586	800	0	50.00
51.00	05100	RECOVERY ROOM	0	620	2,986	100	0	51.00
53.00	05300	ANESTHESIOLOGY	0	414	0	550	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,827	6,179	0	0	54.00
54.01	03630	ULTRA SOUND	0	320	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	589	0	50	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	4,200	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	310	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	2,490	0	125	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,196	9,582	125	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,443	10,580	225	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	285	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	288	0	0	0	90.01
91.00	09100	EMERGENCY	0	7,109	20,540	1,100	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	112,072	466,474	7,000	60,744	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	120	0	100	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND RAISING	0	0	0	25	0	194.01
194.02	07952	MARKETING OTHER	0	0	0	25	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	2,190,688	58,717	1,074,248	1,524,367	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	19.526241	0.125874	150.244476	25.094939	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	57,789	4,357	22,279	26,479	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.515090	0.009340	3.115944	0.435911	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0181

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

Worksheet B-1

Date/Time Prepared:
5/31/2019 6:55 am

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVIC)	DIETARY (MEALS SERVED)	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	6.00	7.00	8.00	9.00	10.00	207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0181

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

Worksheet B-1

Date/Time Prepared:
5/31/2019 6:55 am

Cost Center Description			CAFETERIA (FTES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSNG HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	24,994					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	921	0	352,792			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	306	0	0	1,849,930		14.00
15.00	01500	PHARMACY	0	0	0	0	461,199	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,061	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	186	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,522	0	198,058	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,622	0	33,728	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	2,192	0	45,586	0	0	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	934	0	19,431	0	0	50.00
51.00	05100	RECOVERY ROOM	255	0	5,314	0	0	51.00
53.00	05300	ANESTHESIOLOGY	81	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	892	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	211	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,019	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	97	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	927	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	200	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	336	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,759,094	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	90,836	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	460,075	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	2,436	0	50,675	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,198	0	352,792	1,849,930	460,075	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	796	0	0	0	1,124	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND RAISING	0	0	0	0	0	194.01
194.02	07952	MARKETING OTHER	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	193,402	0	1,394,315	232,705	3,626,910	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.737937	0.000000	3.952230	0.125791	7.864089	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	13,508	0	31,753	11,464	39,490	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.540450	0.000000	0.090005	0.006197	0.085625	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0181

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

Worksheet B-1

Date/Time Prepared:
5/31/2019 6:55 am

Cost Center Description		CAFETERIA (FTES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)	11.00	12.00	13.00	14.00	15.00	207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0181

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

Worksheet B-1

Date/Time Prepared:
5/31/2019 6:55 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
		16.00	17.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	131,150	16.00
17.00	01700	SOCIAL SERVICE	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	74,324	30.00
31.00	03100	INTENSIVE CARE UNIT	8,053	31.00
40.00	04000	SUBPROVIDER - IPF	15,773	40.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	8,000	50.00
51.00	05100	RECOVERY ROOM	0	51.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
54.01	03630	ULTRA SOUND	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	55.00
56.00	05600	RADIOISOTOPE	0	56.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MRI	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
74.00	07400	RENAL DIALYSIS	0	74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	90.00
90.01	09001	WOUND CARE	0	90.01
91.00	09100	EMERGENCY	25,000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	131,150	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
191.00	19100	RESEARCH	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	0	192.01
193.00	19300	NONPAID WORKERS	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	194.00
194.01	07951	FUND RAISING	0	194.01
194.02	07952	MARKETING OTHER	0	194.02
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,115,920	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.508730	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	15,262	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.116371	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	0.545410	206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0181

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

Worksheet B-1

Date/Time Prepared:
5/31/2019 6:55 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)		
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)	16.00	17.00		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0181

Period:
From 01/01/2018
To 12/31/2018Worksheet C
Part I
Date/Time Prepared:
5/31/2019 6:55 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,988,443		12,988,443	0	12,988,443	30.00
31.00	03100	INTENSIVE CARE UNIT	2,470,503		2,470,503	0	2,470,503	31.00
40.00	04000	SUBPROVIDER - IPF	3,540,796		3,540,796	0	3,540,796	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,574,854		1,574,854	20,021	1,594,875	50.00
51.00	05100	RECOVERY ROOM	380,197		380,197	0	380,197	51.00
53.00	05300	ANESTHESIOLOGY	184,746		184,746	0	184,746	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,802,102		1,802,102	4,392	1,806,494	54.00
54.01	03630	ULTRA SOUND	301,890		301,890	0	301,890	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	172,362		172,362	0	172,362	57.00
58.00	05800	MRI	44,524		44,524	0	44,524	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	2,358,123		2,358,123	0	2,358,123	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	339,176		339,176	0	339,176	63.00
65.00	06500	RESPIRATORY THERAPY	1,034,634	0	1,034,634	12,663	1,047,297	65.00
66.00	06600	PHYSICAL THERAPY	383,811	0	383,811	0	383,811	66.00
68.00	06800	SPEECH PATHOLOGY	34,446	0	34,446	0	34,446	68.00
69.00	06900	ELECTROCARDIOLOGY	347,941		347,941	0	347,941	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,301,591		1,301,591	0	1,301,591	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,036		25,036	0	25,036	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,336,740		4,336,740	0	4,336,740	73.00
74.00	07400	RENAL DIALYSIS	445,917		445,917	0	445,917	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	WOUND CARE	7,185		7,185	0	7,185	90.01
91.00	09100	EMERGENCY	3,645,766		3,645,766	70,236	3,716,002	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,704,487		2,704,487		2,704,487	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	40,425,270	0	40,425,270	107,312	40,532,582	200.00
201.00		Less Observation Beds	2,704,487		2,704,487		2,704,487	201.00
202.00		Total (see instructions)	37,720,783	0	37,720,783	107,312	37,828,095	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0181

Period:
From 01/01/2018
To 12/31/2018Worksheet C
Part I
Date/Time Prepared:
5/31/2019 6:55 am

			Title XVIII			Hospital	PPS		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	16,643,871		16,643,871			30.00	
31.00	03100	INTENSIVE CARE UNIT	4,582,890		4,582,890			31.00	
40.00	04000	SUBPROVIDER - IPF	5,522,635		5,522,635			40.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,038,618	595,107	1,633,725	0.963965	0.000000	50.00	
51.00	05100	RECOVERY ROOM	454,918	379,037	833,955	0.455896	0.000000	51.00	
53.00	05300	ANESTHESIOLOGY	711,361	426,366	1,137,727	0.162382	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,284,820	2,190,600	3,475,420	0.518528	0.000000	54.00	
54.01	03630	ULTRA SOUND	211,216	490,295	701,511	0.430343	0.000000	54.01	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00	
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00	
57.00	05700	CT SCAN	1,658,586	4,509,713	6,168,299	0.027943	0.000000	57.00	
58.00	05800	MRI	60,158	86,877	147,035	0.302812	0.000000	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00	
60.00	06000	LABORATORY	8,943,075	9,722,058	18,665,133	0.126338	0.000000	60.00	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,134,811	296,969	1,431,780	0.236891	0.000000	63.00	
65.00	06500	RESPIRATORY THERAPY	6,430,388	1,813,187	8,243,575	0.125508	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	685,457	359,842	1,045,299	0.367178	0.000000	66.00	
68.00	06800	SPEECH PATHOLOGY	44,811	8,442	53,253	0.646837	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	2,010,935	1,569,425	3,580,360	0.097180	0.000000	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,308,672	996,220	4,304,892	0.302352	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	48,058	17,445	65,503	0.382212	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	5,716,206	1,947,030	7,663,236	0.565915	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	803,903	81,667	885,570	0.503537	0.000000	74.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00	
90.01	09001	WOUND CARE	42,094	53,430	95,524	0.075217	0.000000	90.01	
91.00	09100	EMERGENCY	1,942,078	9,475,364	11,417,442	0.319315	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	35,365	4,074,818	4,110,183	0.657997	0.000000	92.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	63,314,926	39,093,892	102,408,818			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	63,314,926	39,093,892	102,408,818			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0181

Period:
From 01/01/2018
To 12/31/2018Worksheet C
Part I
Date/Time Prepared:
5/31/2019 6:55 am

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.976220			50.00
51.00	05100	RECOVERY ROOM	0.455896			51.00
53.00	05300	ANESTHESIOLOGY	0.162382			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.519792			54.00
54.01	03630	ULTRA SOUND	0.430343			54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000			55.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.027943			57.00
58.00	05800	MRI	0.302812			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.126338			60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.236891			63.00
65.00	06500	RESPIRATORY THERAPY	0.127044			65.00
66.00	06600	PHYSICAL THERAPY	0.367178			66.00
68.00	06800	SPEECH PATHOLOGY	0.646837			68.00
69.00	06900	ELECTROCARDIOLOGY	0.097180			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.302352			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.382212			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.565915			73.00
74.00	07400	RENAL DIALYSIS	0.503537			74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
90.01	09001	WOUND CARE	0.075217			90.01
91.00	09100	EMERGENCY	0.325467			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.657997			92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0181

Period:
From 01/01/2018
To 12/31/2018Worksheet C
Part I
Date/Time Prepared:
5/31/2019 6:55 am

			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	12,988,443		12,988,443	0	12,988,443	30.00
31.00	03100	INTENSIVE CARE UNIT	2,470,503		2,470,503	0	2,470,503	31.00
40.00	04000	SUBPROVIDER - IPF	3,540,796		3,540,796	0	3,540,796	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,574,854		1,574,854	20,021	1,594,875	50.00
51.00	05100	RECOVERY ROOM	380,197		380,197	0	380,197	51.00
53.00	05300	ANESTHESIOLOGY	184,746		184,746	0	184,746	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,802,102		1,802,102	4,392	1,806,494	54.00
54.01	03630	ULTRA SOUND	301,890		301,890	0	301,890	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	172,362		172,362	0	172,362	57.00
58.00	05800	MRI	44,524		44,524	0	44,524	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	2,358,123		2,358,123	0	2,358,123	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	339,176		339,176	0	339,176	63.00
65.00	06500	RESPIRATORY THERAPY	1,034,634	0	1,034,634	12,663	1,047,297	65.00
66.00	06600	PHYSICAL THERAPY	383,811	0	383,811	0	383,811	66.00
68.00	06800	SPEECH PATHOLOGY	34,446	0	34,446	0	34,446	68.00
69.00	06900	ELECTROCARDIOLOGY	347,941		347,941	0	347,941	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,301,591		1,301,591	0	1,301,591	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,036		25,036	0	25,036	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,336,740		4,336,740	0	4,336,740	73.00
74.00	07400	RENAL DIALYSIS	445,917		445,917	0	445,917	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	WOUND CARE	7,185		7,185	0	7,185	90.01
91.00	09100	EMERGENCY	3,645,766		3,645,766	70,236	3,716,002	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,704,487		2,704,487		2,704,487	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	40,425,270	0	40,425,270	107,312	40,532,582	200.00
201.00		Less Observation Beds	2,704,487		2,704,487		2,704,487	201.00
202.00		Total (see instructions)	37,720,783	0	37,720,783	107,312	37,828,095	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0181

Period:
From 01/01/2018
To 12/31/2018Worksheet C
Part I
Date/Time Prepared:
5/31/2019 6:55 am

			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	24,291,707		24,291,707			30.00
31.00	03100	INTENSIVE CARE UNIT	4,885,802		4,885,802			31.00
40.00	04000	SUBPROVIDER - IPF	44,000		44,000			40.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,870,650	1,412,545	6,283,195	0.250645	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,057,792	671,258	1,729,050	0.219888	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	1,702,461	776,575	2,479,036	0.074523	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	809,288	1,781,484	2,590,772	0.695585	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0.000000	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
56.00	05600	RADIOISOTOPE	1,714,588	343,214	2,057,802	0.000000	0.000000	56.00
57.00	05700	CT SCAN	3,537,557	3,156,027	6,693,584	0.025750	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	13,436,626	6,685,067	20,121,693	0.117193	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	715,286	64,292	779,578	0.435076	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	11,684,314	606,147	12,290,461	0.084182	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,768,656	278,474	2,047,130	0.187487	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	78,334	11,752	90,086	0.382368	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,308,963	619,783	2,928,746	0.118802	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,372,362	1,201,230	3,573,592	0.364225	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,727,730	684,753	9,412,483	0.460743	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,894,732	2,209	1,896,941	0.235072	0.000000	74.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	WOUND CARE	0	0	0	0.000000	0.000000	90.01
91.00	09100	EMERGENCY	1,933,655	4,818,614	6,752,269	0.539932	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,113,946	1,113,946	2.427844	0.000000	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	87,834,503	24,227,370	112,061,873			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	87,834,503	24,227,370	112,061,873			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0181

Period:
From 01/01/2018
To 12/31/2018Worksheet C
Part I
Date/Time Prepared:
5/31/2019 6:55 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.253832			50.00
51.00	05100	RECOVERY ROOM	0.219888			51.00
53.00	05300	ANESTHESIOLOGY	0.074523			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.697280			54.00
54.01	03630	ULTRA SOUND	0.000000			54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000			55.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.025750			57.00
58.00	05800	MRI	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.117193			60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.435076			63.00
65.00	06500	RESPIRATORY THERAPY	0.085212			65.00
66.00	06600	PHYSICAL THERAPY	0.187487			66.00
68.00	06800	SPEECH PATHOLOGY	0.382368			68.00
69.00	06900	ELECTROCARDIOLOGY	0.118802			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.364225			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.460743			73.00
74.00	07400	RENAL DIALYSIS	0.235072			74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
90.01	09001	WOUND CARE	0.000000			90.01
91.00	09100	EMERGENCY	0.550334			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.427844			92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

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

Provider CCN: 14-0181

Period:
From 01/01/2018
To 12/31/2018Worksheet C
Part II
Date/Time Prepared:
5/31/2019 6:55 am

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	1,574,854	118,436	1,456,418	0	0
51.00	05100	RECOVERY ROOM	380,197	8,873	371,324	0	0
53.00	05300	ANESTHESIOLOGY	184,746	27,266	157,480	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,802,102	74,792	1,727,310	0	0
54.01	03630	ULTRA SOUND	301,890	20,764	281,126	0	0
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	172,362	3,943	168,419	0	0
58.00	05800	MRI	44,524	400	44,124	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	2,358,123	44,253	2,313,870	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	339,176	5,827	333,349	0	0
65.00	06500	RESPIRATORY THERAPY	1,034,634	37,511	997,123	0	0
66.00	06600	PHYSICAL THERAPY	383,811	18,161	365,650	0	0
68.00	06800	SPEECH PATHOLOGY	34,446	3,602	30,844	0	0
69.00	06900	ELECTROCARDIOLOGY	347,941	26,807	321,134	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,301,591	20,608	1,280,983	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,036	685	24,351	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	4,336,740	45,852	4,290,888	0	0
74.00	07400	RENAL DIALYSIS	445,917	5,123	440,794	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
90.01	09001	WOUND CARE	7,185	1,192	5,993	0	0
91.00	09100	EMERGENCY	3,645,766	70,651	3,575,115	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,704,487	78,884	2,625,603	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	21,425,528	613,630	20,811,898	0	0
201.00		Less Observation Beds	2,704,487	78,884	2,625,603	0	0
202.00		Total (line 200 minus line 201)	18,721,041	534,746	18,186,295	0	0

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

Provider CCN: 14-0181

Period:
From 01/01/2018
To 12/31/2018Worksheet C
Part II
Date/Time Prepared:
5/31/2019 6:55 am

Cost Center Description			Title XIX		Hospital	PPS
			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	1,574,854	1,633,725	0.963965	50.00
51.00	05100	RECOVERY ROOM	380,197	833,955	0.455896	51.00
53.00	05300	ANESTHESIOLOGY	184,746	1,137,727	0.162382	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,802,102	3,475,420	0.518528	54.00
54.01	03630	ULTRA SOUND	301,890	701,511	0.430343	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	56.00
57.00	05700	CT SCAN	172,362	6,168,299	0.027943	57.00
58.00	05800	MRI	44,524	147,035	0.302812	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	59.00
60.00	06000	LABORATORY	2,358,123	18,665,133	0.126338	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	339,176	1,431,780	0.236891	63.00
65.00	06500	RESPIRATORY THERAPY	1,034,634	8,243,575	0.125508	65.00
66.00	06600	PHYSICAL THERAPY	383,811	1,045,299	0.367178	66.00
68.00	06800	SPEECH PATHOLOGY	34,446	53,253	0.646837	68.00
69.00	06900	ELECTROCARDIOLOGY	347,941	3,580,360	0.097180	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,301,591	4,304,892	0.302352	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,036	65,503	0.382212	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,336,740	7,663,236	0.565915	73.00
74.00	07400	RENAL DIALYSIS	445,917	885,570	0.503537	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	90.00
90.01	09001	WOUND CARE	7,185	95,524	0.075217	90.01
91.00	09100	EMERGENCY	3,645,766	11,417,442	0.319315	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,704,487	4,110,183	0.657997	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (sum of lines 50 thru 199)	21,425,528	75,659,422		200.00
201.00		Less Observation Beds	2,704,487	0		201.00
202.00		Total (line 200 minus line 201)	18,721,041	75,659,422		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS				Provider CCN: 14-0181		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part I Date/Time Prepared: 5/31/2019 6:55 am	
				Title XVIII		Hospital		PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)			
		1.00	2.00	3.00	4.00	5.00			
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	378,851	0	378,851	16,055	23.60	30.00		
31.00	INTENSIVE CARE UNIT	62,896		62,896	1,824	34.48	31.00		
40.00	SUBPROVIDER - IPF	97,460	0	97,460	4,078	23.90	40.00		
200.00	Total (lines 30 through 199)	539,207		539,207	21,957		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	7,142	168,551						30.00
31.00	INTENSIVE CARE UNIT	681	23,481						31.00
40.00	SUBPROVIDER - IPF	1,649	39,411						40.00
200.00	Total (lines 30 through 199)	9,472	231,443						200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0181

Period:
From 01/01/2018
To 12/31/2018Worksheet D
Part II
Date/Time Prepared:
5/31/2019 6:55 am

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	118,436	1,633,725	0.072494	595,424	43,165
51.00	05100	RECOVERY ROOM	8,873	833,955	0.010640	143,876	1,531
53.00	05300	ANESTHESIOLOGY	27,266	1,137,727	0.023965	221,834	5,316
54.00	05400	RADIOLOGY-DIAGNOSTIC	74,792	3,475,420	0.021520	572,903	12,329
54.01	03630	ULTRA SOUND	20,764	701,511	0.029599	97,767	2,894
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0
57.00	05700	CT SCAN	3,943	6,168,299	0.000639	745,834	477
58.00	05800	MRI	400	147,035	0.002720	43,063	117
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0
60.00	06000	LABORATORY	44,253	18,665,133	0.002371	4,024,109	9,541
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	5,827	1,431,780	0.004070	301,654	1,228
65.00	06500	RESPIRATORY THERAPY	37,511	8,243,575	0.004550	1,308,050	5,952
66.00	06600	PHYSICAL THERAPY	18,161	1,045,299	0.017374	395,346	6,869
68.00	06800	SPEECH PATHOLOGY	3,602	53,253	0.067639	25,776	1,743
69.00	06900	ELECTROCARDIOLOGY	26,807	3,580,360	0.007487	825,023	6,177
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,608	4,304,892	0.004787	2,174,811	10,411
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	685	65,503	0.010458	25,015	262
73.00	07300	DRUGS CHARGED TO PATIENTS	45,852	7,663,236	0.005983	2,741,560	16,403
74.00	07400	RENAL DIALYSIS	5,123	885,570	0.005785	622,906	3,604
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0.000000	0	0
90.01	09001	WOUND CARE	1,192	95,524	0.012479	3,894	49
91.00	09100	EMERGENCY	70,651	11,417,442	0.006188	641,216	3,968
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	78,884	4,110,183	0.019192	6,174	118
200.00		Total (lines 50 through 199)	613,630	75,659,422		15,516,235	132,154

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0181		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part III Date/Time Prepared: 5/31/2019 6:55 am		
					Title XVIII		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00	
40.00	04000	SUBPROVIDER - IPF		0	0	0	0	0	0	40.00	
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	16,055	0.00	7,142		30.00	
31.00	03100	INTENSIVE CARE UNIT			0	1,824	0.00	681		31.00	
40.00	04000	SUBPROVIDER - IPF		0	0	4,078	0.00	1,649		40.00	
200.00		Total (lines 30 through 199)			0	21,957		9,472		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	
40.00	04000	SUBPROVIDER - IPF		0						40.00	
200.00		Total (lines 30 through 199)		0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0181		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part IV Date/Time Prepared: 5/31/2019 6:55 am	
			Title XVIII		Hospital		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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 PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
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
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: 14-0181		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part IV Date/Time Prepared: 5/31/2019 6:55 am	
			Title XVIII		Hospital		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	1,633,725	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	833,955	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,137,727	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	3,475,420	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	701,511	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	6,168,299	0.000000	57.00
58.00	05800	MRI	0	0	0	147,035	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	18,665,133	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	1,431,780	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,243,575	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,045,299	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	53,253	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,580,360	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,304,892	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	65,503	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,663,236	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	885,570	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	WOUND CARE	0	0	0	95,524	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	11,417,442	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,110,183	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	75,659,422		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0181		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part IV Date/Time Prepared: 5/31/2019 6:55 am	
				Title XVIII		Hospital		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	595,424	0	126,962	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	143,876	0	74,514	0	51.00
53.00	05300	ANESTHESIOLOGY		0.000000	221,834	0	65,674	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	572,903	0	335,454	0	54.00
54.01	03630	ULTRA SOUND		0.000000	97,767	0	34,490	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN		0.000000	745,834	0	684,750	0	57.00
58.00	05800	MRI		0.000000	43,063	0	19,023	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	4,024,109	0	1,060,009	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0.000000	301,654	0	13,455	0	63.00
65.00	06500	RESPIRATORY THERAPY		0.000000	1,308,050	0	24,588	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	395,346	0	12,575	0	66.00
68.00	06800	SPEECH PATHOLOGY		0.000000	25,776	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	825,023	0	239,490	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	2,174,811	0	274,873	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	25,015	0	14,996	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	2,741,560	0	265,966	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	622,906	0	16,990	0	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
90.01	09001	WOUND CARE		0.000000	3,894	0	6,576	0	90.01
91.00	09100	EMERGENCY		0.000000	641,216	0	1,064,845	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	6,174	0	634,751	0	92.00
200.00		Total (lines 50 through 199)			15,516,235	0	4,969,981	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0181

Period:
From 01/01/2018
To 12/31/2018Worksheet D
Part V
Date/Time Prepared:
5/31/2019 6:55 am

			Title XVIII		Hospital		PPS	
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.963965	126,962		0	122,387	50.00	
51.00	05100 RECOVERY ROOM	0.455896	74,514		0	33,971	51.00	
53.00	05300 ANESTHESIOLOGY	0.162382	65,674		0	10,664	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.518528	335,454		0	173,942	54.00	
54.01	03630 ULTRA SOUND	0.430343	34,490		0	14,843	54.01	
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0		0	0	55.00	
56.00	05600 RADIOISOTOPE	0.000000	0		0	0	56.00	
57.00	05700 CT SCAN	0.027943	684,750		0	19,134	57.00	
58.00	05800 MRI	0.302812	19,023		0	5,760	58.00	
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0		0	0	59.00	
60.00	06000 LABORATORY	0.126338	1,060,009		0	133,919	60.00	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.236891	13,455		0	3,187	63.00	
65.00	06500 RESPIRATORY THERAPY	0.125508	24,588		0	3,086	65.00	
66.00	06600 PHYSICAL THERAPY	0.367178	12,575		0	4,617	66.00	
68.00	06800 SPEECH PATHOLOGY	0.646837	0		0	0	68.00	
69.00	06900 ELECTROCARDIOLOGY	0.097180	239,490		0	23,274	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0		0	0	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.302352	274,873		0	83,108	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.382212	14,996		0	5,732	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.565915	265,966		0	150,514	73.00	
74.00	07400 RENAL DIALYSIS	0.503537	16,990		0	8,555	74.00	
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0		0	0	90.00	
90.01	09001 WOUND CARE	0.075217	6,576		0	495	90.01	
91.00	09100 EMERGENCY	0.319315	1,064,845		0	340,021	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.657997	634,751		0	417,664	92.00	
200.00	Subtotal (see instructions)		4,969,981		0	1,554,873	200.00	
201.00	Less PBP Clinic Lab. Services-Program Only Charges				0		201.00	
202.00	Net Charges (line 200 - line 201)		4,969,981		0	1,554,873	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0181		Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/31/2019 6:55 am
			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
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 PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CARE	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0181	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Prepared: 5/31/2019 6:55 am		
				Component CCN: 14-S181				
				Title XVIII		Subprovider - IPF	PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	118,436	1,633,725	0.072494	0	0	50.00
51.00	05100	RECOVERY ROOM	8,873	833,955	0.010640	0	0	51.00
53.00	05300	ANESTHESIOLOGY	27,266	1,137,727	0.023965	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	74,792	3,475,420	0.021520	14,828	319	54.00
54.01	03630	ULTRA SOUND	20,764	701,511	0.029599	3,180	94	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	3,943	6,168,299	0.000639	22,996	15	57.00
58.00	05800	MRI	400	147,035	0.002720	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	44,253	18,665,133	0.002371	384,592	912	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	5,827	1,431,780	0.004070	80	0	63.00
65.00	06500	RESPIRATORY THERAPY	37,511	8,243,575	0.004550	11,200	51	65.00
66.00	06600	PHYSICAL THERAPY	18,161	1,045,299	0.017374	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	3,602	53,253	0.067639	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	26,807	3,580,360	0.007487	45,232	339	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,608	4,304,892	0.004787	40,711	195	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	685	65,503	0.010458	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,852	7,663,236	0.005983	217,445	1,301	73.00
74.00	07400	RENAL DIALYSIS	5,123	885,570	0.005785	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	WOUND CARE	1,192	95,524	0.012479	0	0	90.01
91.00	09100	EMERGENCY	70,651	11,417,442	0.006188	160,231	992	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	4,110,183	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	534,746	75,659,422		900,495	4,218	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0181 Component CCN: 14-S181		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part IV Date/Time Prepared: 5/31/2019 6:55 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND		0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
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 PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
90.01	09001	WOUND CARE		0	0	0	0	0	90.01
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
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: 14-0181 Component CCN: 14-S181		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part IV Date/Time Prepared: 5/31/2019 6:55 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	1,633,725	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	833,955	0.000000	51.00
53.00	05300	ANESTHESIOLOGY		0	0	0	1,137,727	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	3,475,420	0.000000	54.00
54.01	03630	ULTRA SOUND		0	0	0	701,511	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	6,168,299	0.000000	57.00
58.00	05800	MRI		0	0	0	147,035	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	18,665,133	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0	0	0	1,431,780	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	8,243,575	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	1,045,299	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	53,253	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	3,580,360	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	4,304,892	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	65,503	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	7,663,236	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	885,570	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0.000000	90.00
90.01	09001	WOUND CARE		0	0	0	95,524	0.000000	90.01
91.00	09100	EMERGENCY		0	0	0	11,417,442	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	4,110,183	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	75,659,422		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0181 Component CCN: 14-S181		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part IV Date/Time Prepared: 5/31/2019 6:55 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	14,828	0	305	0	54.00
54.01	03630	ULTRA SOUND		0.000000	3,180	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN		0.000000	22,996	0	0	0	57.00
58.00	05800	MRI		0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	384,592	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0.000000	80	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY		0.000000	11,200	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY		0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	45,232	0	1,364	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	40,711	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	217,445	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
90.01	09001	WOUND CARE		0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY		0.000000	160,231	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			900,495	0	1,669	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0181 Component CCN: 14-S181		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part V Date/Time Prepared: 5/31/2019 6:55 am	
			Title XVIII		Subprovider - IPF		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	0.963965	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.455896	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.162382	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.518528	305	0	0	158	54.00
54.01	03630	ULTRA SOUND	0.430343	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.027943	0	0	0	0	57.00
58.00	05800	MRI	0.302812	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.126338	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.236891	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.125508	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.367178	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.646837	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.097180	1,364	0	0	133	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.302352	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.382212	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.565915	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.503537	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CARE	0.075217	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.319315	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.657997	0	0	0	0	92.00
200.00		Subtotal (see instructions)		1,669	0	0	291	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		1,669	0	0	291	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0181 Component CCN: 14-S181		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part V Date/Time Prepared: 5/31/2019 6:55 am		
			Title XVIII		Subprovider - IPF		PPS		
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0					50.00
51.00	05100	RECOVERY ROOM	0	0					51.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
54.01	03630	ULTRA SOUND	0	0					54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0					55.00
56.00	05600	RADIOISOTOPE	0	0					56.00
57.00	05700	CT SCAN	0	0					57.00
58.00	05800	MRI	0	0					58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0					59.00
60.00	06000	LABORATORY	0	0					60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0					63.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
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 PATIENT	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0					73.00
74.00	07400	RENAL DIALYSIS	0	0					74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0					90.00
90.01	09001	WOUND CARE	0	0					90.01
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0					92.00
200.00		Subtotal (see instructions)	0	0					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	0	0					202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS				Provider CCN: 14-0181		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part I Date/Time Prepared: 5/31/2019 6:55 am	
				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	378,851	0	378,851	16,055	23.60	30.00		
31.00	INTENSIVE CARE UNIT	62,896		62,896	1,824	34.48	31.00		
40.00	SUBPROVIDER - IPF	97,460	0	97,460	4,078	23.90	40.00		
200.00	Total (lines 30 through 199)	539,207		539,207	21,957		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	918	21,665						30.00
31.00	INTENSIVE CARE UNIT	29	1,000						31.00
40.00	SUBPROVIDER - IPF	164	3,920						40.00
200.00	Total (lines 30 through 199)	1,111	26,585						200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0181

Period:
From 01/01/2018
To 12/31/2018Worksheet D
Part II
Date/Time Prepared:
5/31/2019 6:55 am

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	118,436	6,283,195	0.018850	0	0 50.00
51.00	05100	RECOVERY ROOM	8,873	1,729,050	0.005132	0	0 51.00
53.00	05300	ANESTHESIOLOGY	27,266	2,479,036	0.010999	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	74,792	2,590,772	0.028869	0	0 54.00
54.01	03630	ULTRA SOUND	20,764	0	0.000000	0	0 54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0 55.00
56.00	05600	RADIOISOTOPE	0	2,057,802	0.000000	0	0 56.00
57.00	05700	CT SCAN	3,943	6,693,584	0.000589	0	0 57.00
58.00	05800	MRI	400	0	0.000000	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0 59.00
60.00	06000	LABORATORY	44,253	20,121,693	0.002199	0	0 60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	5,827	779,578	0.007475	0	0 63.00
65.00	06500	RESPIRATORY THERAPY	37,511	12,290,461	0.003052	0	0 65.00
66.00	06600	PHYSICAL THERAPY	18,161	2,047,130	0.008871	0	0 66.00
68.00	06800	SPEECH PATHOLOGY	3,602	90,086	0.039984	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	26,807	2,928,746	0.009153	0	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,608	3,573,592	0.005767	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	685	0	0.000000	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,852	9,412,483	0.004871	0	0 73.00
74.00	07400	RENAL DIALYSIS	5,123	1,896,941	0.002701	0	0 74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0.000000	0	0 90.00
90.01	09001	WOUND CARE	1,192	0	0.000000	0	0 90.01
91.00	09100	EMERGENCY	70,651	6,752,269	0.010463	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	78,884	1,113,946	0.070815	0	0 92.00
200.00		Total (lines 50 through 199)	613,630	82,840,364		0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0181		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part III Date/Time Prepared: 5/31/2019 6:55 am	
					Title XIX		Hospital		PPS	
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
					1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF		0	0	0	0	0	0	40.00
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
					4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	16,055	0.00		918	30.00
31.00	03100	INTENSIVE CARE UNIT			0	1,824	0.00		29	31.00
40.00	04000	SUBPROVIDER - IPF		0	0	4,078	0.00		164	40.00
200.00		Total (lines 30 through 199)			0	21,957			1,111	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
40.00	04000	SUBPROVIDER - IPF		0						40.00
200.00		Total (lines 30 through 199)		0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0181		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part IV Date/Time Prepared: 5/31/2019 6:55 am	
			Title XIX		Hospital		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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 PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
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
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: 14-0181

Period:
From 01/01/2018
To 12/31/2018Worksheet D
Part IV
Date/Time Prepared:
5/31/2019 6:55 am

				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	6,283,195	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,729,050	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,479,036	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	2,590,772	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	2,057,802	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	6,693,584	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	20,121,693	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	779,578	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	12,290,461	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,047,130	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	90,086	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,928,746	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,573,592	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,412,483	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,896,941	0.000000	74.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	WOUND CARE	0	0	0	0	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	6,752,269	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,113,946	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	82,840,364		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0181

Period:
From 01/01/2018
To 12/31/2018Worksheet D
Part IV
Date/Time Prepared:
5/31/2019 6:55 am

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
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	51.00
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	03630	ULTRA SOUND	0.000000	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	0	0	0	60.00
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
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 PATIENT	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
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	0	0	0	90.00
90.01	09001	WOUND CARE	0.000000	0	0	0	90.01
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
200.00		Total (lines 50 through 199)		0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0181	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/31/2019 6:55 am
		Title XVIII	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		16,055	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		16,055	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)		12,712	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		7,142	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		12,988,443	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		12,988,443	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)		12,988,443	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)		809.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,777,878	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)		5,777,878	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0181	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/31/2019 6:55 am
			Title XVIII	Hospital	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	2,470,503	1,824	1,354.44	681	922,374
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					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					4,789,986
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					11,490,238
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					192,032
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					132,154
52.00 Total Program excludable cost (sum of lines 50 and 51)					324,186
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					11,166,052
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					3,343
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					809.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					2,704,487

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0181

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

Worksheet D-1

Date/Time Prepared:
5/31/2019 6:55 am

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	378,851	12,988,443	0.029168	2,704,487	78,884	90.00
91.00 Nursing School cost	0	12,988,443	0.000000	2,704,487	0	91.00
92.00 Allied health cost	0	12,988,443	0.000000	2,704,487	0	92.00
93.00 All other Medical Education	0	12,988,443	0.000000	2,704,487	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0181 Component CCN: 14-S181	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/31/2019 6:55 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,078	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,078	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)		4,078	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,649	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,540,796	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,540,796	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)		3,540,796	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)		868.27	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,431,777	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,431,777	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0181 Component CCN: 14-S181	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/31/2019 6:55 am
			Title XVIII	Subprovider - IPF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE					47.00
Cost Center Description					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					251,659 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,683,436 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)					39,411 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					4,218 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					43,629 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,639,807 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0 54.00
55.00 Target amount per discharge					0.00 55.00
56.00 Target amount (line 54 x line 55)					0 56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00 Bonus payment (see instructions)					0 58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00 Relief payment (see instructions)					0 62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					0 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0181 Component CCN: 14-S181		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/31/2019 6:55 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	97,460	3,540,796	0.027525	0	0	90.00
91.00	Nursing School cost	0	3,540,796	0.000000	0	0	91.00
92.00	Allied health cost	0	3,540,796	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,540,796	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0181	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/31/2019 6:55 am
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)		16,055	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		16,055	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)		12,712	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		918	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		12,988,443	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		12,988,443	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)		12,988,443	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)		809.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		742,662	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)		742,662	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0181

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

Worksheet D-1

Date/Time Prepared:
5/31/2019 6:55 am

		Title XIX		Hospital	PPS		
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,470,503	1,824	1,354.44	29	39,279	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						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)					781,941	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)					22,665	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)					22,665	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					759,276	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)					3,343	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					809.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,704,487	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0181

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

Worksheet D-1

Date/Time Prepared:
5/31/2019 6:55 am

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	378,851	12,988,443	0.029168	2,704,487	78,884
91.00	Nursing School cost	0	12,988,443	0.000000	2,704,487	0
92.00	Allied health cost	0	12,988,443	0.000000	2,704,487	0
93.00	All other Medical Education	0	12,988,443	0.000000	2,704,487	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0181	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/31/2019 6:55 am	
Cost Center Description		Title XVIII	Hospital	PPS	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		9,037,777	30.00
31.00	03100	INTENSIVE CARE UNIT		1,690,748	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.976220	595,424	50.00
51.00	05100	RECOVERY ROOM	0.455896	143,876	51.00
53.00	05300	ANESTHESIOLOGY	0.162382	221,834	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.519792	572,903	54.00
54.01	03630	ULTRA SOUND	0.430343	97,767	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	56.00
57.00	05700	CT SCAN	0.027943	745,834	57.00
58.00	05800	MRI	0.302812	43,063	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.126338	4,024,109	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.236891	301,654	63.00
65.00	06500	RESPIRATORY THERAPY	0.127044	1,308,050	65.00
66.00	06600	PHYSICAL THERAPY	0.367178	395,346	66.00
68.00	06800	SPEECH PATHOLOGY	0.646837	25,776	68.00
69.00	06900	ELECTROCARDIOLOGY	0.097180	825,023	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.302352	2,174,811	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.382212	25,015	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.565915	2,741,560	73.00
74.00	07400	RENAL DIALYSIS	0.503537	622,906	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
90.01	09001	WOUND CARE	0.075217	3,894	90.01
91.00	09100	EMERGENCY	0.325467	641,216	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.657997	6,174	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		15,516,235	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)		15,516,235	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0181 Component CCN: 14-S181	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/31/2019 6:55 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		2,232,523		40.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.976220	0	0	50.00
51.00	05100 RECOVERY ROOM	0.455896	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.162382	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.519792	14,828	7,707	54.00
54.01	03630 ULTRA SOUND	0.430343	3,180	1,368	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700 CT SCAN	0.027943	22,996	643	57.00
58.00	05800 MRI	0.302812	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.126338	384,592	48,589	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.236891	80	19	63.00
65.00	06500 RESPIRATORY THERAPY	0.127044	11,200	1,423	65.00
66.00	06600 PHYSICAL THERAPY	0.367178	0	0	66.00
68.00	06800 SPEECH PATHOLOGY	0.646837	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.097180	45,232	4,396	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.302352	40,711	12,309	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.382212	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.565915	217,445	123,055	73.00
74.00	07400 RENAL DIALYSIS	0.503537	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	09001 WOUND CARE	0.075217	0	0	90.01
91.00	09100 EMERGENCY	0.325467	160,231	52,150	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.657997	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		900,495	251,659	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)		900,495		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0181	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/31/2019 6:55 am
		Title XVIII	Hospital	PPS
			1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		5,576,960	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		1,348,195	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)		346,642	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)		112.84	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)		19.00	30.00
31.00	Percentage of Medicaid patient days (see instructions)		31.96	31.00
32.00	Sum of lines 30 and 31		50.96	32.00
33.00	Allowable disproportionate share percentage (see instructions)		31.26	33.00
34.00	Disproportionate share adjustment (see instructions)		541,202	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0181	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/31/2019 6:55 am
		Title XVIII	Hospital	PPS
			Prior to 10/1	On/After 10/1
			1.00	2.00
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		6,766,695,164	8,272,872,447
35.01	Factor 3 (see instructions)		0.000198544	0.000122527
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		1,343,488	1,013,650
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		1,004,855	255,496
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,260,351	
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	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	
47.00	Subtotal (see instructions)		9,073,350	
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions))		0	
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		9,073,350	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		627,112	
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	
53.00	Nursing and Allied Health Managed Care payment		0	
54.00	Special add-on payments for new technologies		0	
54.01	Islet isolation add-on payment		0	
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	
59.00	Total (sum of amounts on lines 49 through 58)		9,700,462	
60.00	Primary payer payments		0	
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		9,700,462	
62.00	Deductibles billed to program beneficiaries		651,153	
63.00	Coinurance billed to program beneficiaries		150,726	
64.00	Allowable bad debts (see instructions)		184,490	
65.00	Adjusted reimbursable bad debts (see instructions)		119,919	
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		44,951	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		9,018,502	
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	
70.87	Demonstration payment adjustment amount before sequestration		0	
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	
70.92	Bundled Model 1 discount amount (see instructions)		0	
70.93	HVBP payment adjustment amount (see instructions)		-39,698	
70.94	HRR adjustment amount (see instructions)		-43,158	
70.95	Recovery of accelerated depreciation		0	

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0181

Period:
From 01/01/2018
To 12/31/2018Worksheet E
Part A
Date/Time Prepared:
5/31/2019 6:55 am

		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96	
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97	
70.98	Low Volume Payment-3		0	70.98	
70.99	HAC adjustment amount (see instructions)		96,176	70.99	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		8,839,470	71.00	
71.01	Sequestration adjustment (see instructions)		176,789	71.01	
71.02	Demonstration payment adjustment amount after sequestration		0	71.02	
72.00	Interim payments		9,629,475	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)		-966,794	74.00	
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		200,300	75.00	
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00	
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00	
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00	
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00	
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00	
95.00	Time value of money for operating expenses (see instructions)		0	95.00	
96.00	Time value of money for capital related expenses (see instructions)		0	96.00	
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	100.00	
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00	
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00	
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00	
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00	
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00	
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00	
202.00	Medicare discharges (see instructions)			202.00	
203.00	Case-mix adjustment factor (see instructions)			203.00	
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount			204.00	
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00	
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00	
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00	
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00	
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00	
210.00	Reserved for future use			210.00	
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00	
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00	
213.00	Low-volume adjustment (see instructions)			213.00	
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00	

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0181

Period:
From 01/01/2018
To 12/31/2018Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/31/2019 6:55 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	5,576,960	0	5,576,960		5,576,960
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,348,195	0		1,348,195	1,348,195
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00	346,642	0	263,375	83,267	346,642
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	0	0	0	0	0
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	0
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
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	0.000000	0
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.3126	0.3126	0.3126	0.3126	0
11.00	Disproportionate share adjustment (see instructions)	34.00	541,202	0	435,840	105,362	541,202
11.01	Uncompensated care payments	36.00	1,260,351	0	1,351,240	407,345	1,758,585
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	9,073,350	0	7,129,181	1,944,169	9,073,350
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	9,073,350	0	7,129,181	1,944,169	9,073,350
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	627,112	0	505,300	121,812	627,112
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0
17.01	Net organ aquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0181

Period:
From 01/01/2018
To 12/31/2018Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/31/2019 6:55 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	7,634,481	2,065,981	9,700,462
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	5.00
20.00	Capital DRG other than outlier	1.00	563,897	0	454,215	109,682	563,897
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	1,919	0	1,711	208	1,919
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1087	0.1087	0.1087	0.1087	
25.00	Disproportionate share adjustment (see instructions)	11.00	61,296	0	49,374	11,922	61,296
26.00	Total prospective capital payments (see instructions)	12.00	627,112	0	505,300	121,812	627,112
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.054643	0.054643	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			417,171		417,171
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				112,891	112,891
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0181

Period:
From 01/01/2018
To 12/31/2018Worksheet E
Part A Exhibit 5
Date/Time Prepared:
5/31/2019 6:55 am

		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	5,576,960	5,576,960		5,576,960	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,348,195		1,348,195	1,348,195	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	346,642	263,375	83,267	346,642	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	0.3126	0.3126	0.3126		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	541,202	435,840	105,362	541,202	11.00
11.01	Uncompensated care payments	36.00	1,260,351	1,004,855	255,496	1,260,351	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	9,073,350	7,281,030	1,792,320	9,073,350	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	9,073,350	7,281,030	1,792,320	9,073,350	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	627,112	505,300	121,812	627,112	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			7,786,330	1,914,132	9,700,462	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0181

Period:
From 01/01/2018
To 12/31/2018Worksheet E
Part A Exhibit 5
Date/Time Prepared:
5/31/2019 6:55 am

		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	563,897	454,215	109,682	563,897	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	1,919	1,711	208	1,919	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	0.1087	0.1087	0.1087		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	61,296	49,374	11,922	61,296	25.00
26.00	Total prospective capital payments (see instructions)	12.00	627,112	505,300	121,812	627,112	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	-39,698	-26,091	-13,607	-39,698	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-43,158	-41,270	-1,888	-43,158	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	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		77,190	18,986	96,176	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0181	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/31/2019 6:55 am
		Title XVIII	Hospital	PPS
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		1,554,873	2.00
3.00	OPPS payments		909,884	3.00
4.00	Outlier payment (see instructions)		23,061	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	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)		0	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)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	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)		0	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)		932,945	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)		198,815	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)		734,130	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)		734,130	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		734,130	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)		38,219	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		24,842	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		9,222	36.00
37.00	Subtotal (see instructions)		758,972	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)			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)		758,972	40.00
40.01	Sequestration adjustment (see instructions)		15,179	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		802,588	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-58,795	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0181 Component CCN: 14-S181	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/31/2019 6:55 am
		Title XVIII	Subprovider - IPF	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPSS (see instructions)		291	2.00
3.00	OPPS payments		428	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	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)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	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)		0	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)		428	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)		86	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)		342	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)		342	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		342	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)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		342	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)		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)		342	40.00
40.01	Sequestration adjustment (see instructions)		7	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		335	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		0	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: 14-0181

Period:
From 01/01/2018
To 12/31/2018Worksheet E-1
Part I
Date/Time Prepared:
5/31/2019 6:55 am

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		10,214,915		719,444	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		426,041		83,144	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	08/06/2018	378,662		0	3.50
3.51		12/19/2018	632,819		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)		-1,011,481		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)		9,629,475		802,588	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		966,794		58,795	6.02
7.00	Total Medicare program liability (see instructions)		8,662,681		743,793	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: 14-0181 Component CCN: 14-S181		Period: From 01/01/2018 To 12/31/2018		Worksheet E-1 Part I Date/Time Prepared: 5/31/2019 6:55 am	
		Title XVIII		Subprovider - IPF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider						1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1,328,910		335		2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,328,910		335		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		16,782		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		1,345,692		335		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0181

Period:
From 01/01/2018
To 12/31/2018Worksheet E-1
Part II
Date/Time Prepared:
5/31/2019 6:55 am

Title XVIII

Hospital

PPS

1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0181 Component CCN: 14-S181	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part II Date/Time Prepared: 5/31/2019 6:55 am
		Title XVIII	Subprovider - IPF	PPS
		1.00		
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		1,558,938	1.00
2.00	Net IPF PPS Outlier Payments		9,484	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		11.172603	9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1)\}$.		0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		1,568,422	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		0	14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		1,568,422	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		1,568,422	18.00
19.00	Deductibles		96,480	19.00
20.00	Subtotal (line 18 minus line 19)		1,471,942	20.00
21.00	Coinsurance		115,910	21.00
22.00	Subtotal (line 20 minus line 21)		1,356,032	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		26,343	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		17,123	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		5,921	25.00
26.00	Subtotal (sum of lines 22 and 24)		1,373,155	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	27.00
28.00	Other pass through costs (see instructions)		0	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	30.50
30.99	Demonstration payment adjustment amount before sequestration		0	30.99
31.00	Total amount payable to the provider (see instructions)		1,373,155	31.00
31.01	Sequestration adjustment (see instructions)		27,463	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	31.02
32.00	Interim payments		1,328,910	32.00
33.00	Tentative settlement (for contractor use only)		0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)		16,782	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		9,484	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

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

Provider CCN: 14-0181

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

Worksheet G

Date/Time Prepared:
5/31/2019 6:55 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	1,020,477	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	8,182,452	0	0	0	4.00
5.00	Other receivable	1,329,511	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	347,655	0	0	0	7.00
8.00	Prepaid expenses	199,089	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)	11,079,184	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,428,579	0	0	0	12.00
13.00	Land improvements	1,100,274	0	0	0	13.00
14.00	Accumulated depreciation	-1,095,543	0	0	0	14.00
15.00	Buildings	17,790,291	0	0	0	15.00
16.00	Accumulated depreciation	-10,919,698	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	10,770,913	0	0	0	19.00
20.00	Accumulated depreciation	-10,236,354	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	22,128,326	0	0	0	23.00
24.00	Accumulated depreciation	-20,536,849	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	10,429,939	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	740,363	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	740,363	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	22,249,486	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	4,208,884	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,907,886	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,503,847	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,620,617	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	3,902,447	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	3,902,447	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	13,523,064	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	8,726,422				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)	8,726,422	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	22,249,486	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0181

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

Worksheet G-1

Date/Time Prepared:
5/31/2019 6:55 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		10,067,562		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,275,207				2.00
3.00	Total (sum of line 1 and line 2)		8,792,355		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		8,792,355		0		11.00
12.00	TRANSFERS	65,933		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		65,933		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		8,726,422		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	TRANSFERS		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0181

Period:
From 01/01/2018
To 12/31/2018Worksheet G-2
Parts I & II
Date/Time Prepared:
5/31/2019 6:55 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	17,064,915		17,064,915	1.00
2.00	SUBPROVIDER - IPF	5,528,687		5,528,687	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)	22,593,602		22,593,602	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,079,100		5,079,100	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				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	5,079,100		5,079,100	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	27,672,702		27,672,702	17.00
18.00	Ancillary services	36,092,844		36,092,844	18.00
19.00	Outpatient services	0	38,643,601	38,643,601	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	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)	63,765,546	38,643,601	102,409,147	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		41,489,717		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)		41,489,717		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0181

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

Worksheet G-3

Date/Time Prepared:
5/31/2019 6:55 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	102,409,147	1.00
2.00	Less contractual allowances and discounts on patients' accounts	65,625,752	2.00
3.00	Net patient revenues (line 1 minus line 2)	36,783,395	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	41,489,717	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,706,322	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	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	474,470	24.00
24.01	INVESTMENT IN BETTER HEALTH	3,000,139	24.01
24.02	UNREALIZED GAINS & LOSSES	-43,494	24.02
25.00	Total other income (sum of lines 6-24)	3,431,115	25.00
26.00	Total (line 5 plus line 25)	-1,275,207	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,275,207	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0181	Period: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III Date/Time Prepared: 5/31/2019 6:55 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		563,897	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		1,919	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)		39.82	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)		19.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		31.96	8.00
9.00	Sum of lines 7 and 8		50.96	9.00
10.00	Allowable disproportionate share percentage (see instructions)		10.87	10.00
11.00	Disproportionate share adjustment (see instructions)		61,296	11.00
12.00	Total prospective capital payments (see instructions)		627,112	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