

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: 14-0184

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

Worksheet 5
Parts I-III
Date/Time Prepared:
9/26/2018 8:45 am

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.	Date: 9/26/2018 Time: 8:45 am
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)

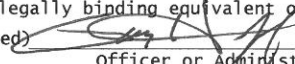
I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HEARTLAND REGIONAL MEDICAL CENTER (14-0184) for the cost reporting period beginning 05/01/2017 and ending 04/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Encryption Information

ECR: Date: 9/26/2018 Time: 8:45 am
4Aw4b6nlrDFrokb1Ak6M6.cXDD9xn0
zh0Rq0WymCPLFP9kPS7WiyE8Z727dL
wynU0udh3w0m76KN

PI: Date: 9/26/2018 Time: 8:45 am
kJcVoLeRWS5LanTACmVewhR1h51lp0
0eNJA0gKetyPpPRAA6IVvVBdKTqPo9
wuxH0e7sQp0VyhbK

(Signed) 
Officer or Administrator of Provider(s)

CFO

Title

9-26-18

Date

		Title v	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-66,609	-18,499	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-66,609	-18,499	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.

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: 14-0184

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

Worksheet 5
Parts I-III
Date/Time Prepared:
9/26/2018 8:45 am

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.

Date: 9/26/2018 Time: 8:45 am

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 HEARTLAND REGIONAL MEDICAL CENTER (14-0184) for the cost reporting period beginning 05/01/2017 and ending 04/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-66,609	-18,499	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-66,609	-18,499	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: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet S-2
Part I
Date/Time Prepared:
9/25/2018 6:18 pm

1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 917 WEST MAIN ST			PO Box:				1.00	
2.00	City: MARION			State: IL		Zip Code: 62959		County: WILLIAMSON	
		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			HEARTLAND REGIONAL MEDICAL CENTER	140184	16060	1	07/01/1996	N P O
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF			HEARTLAND REGIONAL MEDICAL CENTER	14U184	16060		03/23/1999	N P N
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						05/01/2017	04/30/2018	
21.00	Type of Control (see instructions)						4		
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	
22.01	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	
22.02	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	
22.03	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	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3	N	
				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.			2,854	0	0	8	1,137	0
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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet S-2
Part I
Date/Time Prepared:
9/25/2018 6:18 pm

		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)	N		37.01			
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00			
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00			
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00			
		V	XVIII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00		
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete wkst. L, Pt. III and wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00		
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00		
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00		
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete wkst. D-5.				58.00		
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete wkst. D-2, Pt. I.	N			59.00		
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	N			60.00		
		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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From 05/01/2017
To 04/30/2018Worksheet S-2
Part I
Date/Time Prepared:
9/25/2018 6:18 pm

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet S-2
Part I
Date/Time Prepared:
9/25/2018 6:18 pm

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0 115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	62,978	38,652	0 118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	449008	140.00

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: QUORUM HEALTH	Contractor's Name: WISCONSIN PHYSICIAN SERVICES		Contractor's Number: 10101		141.00	
142.00	Street: 1573 MALLORY LANE	PO Box:				142.00	
143.00	City: BRENTWOOD	State: TN		Zip Code: 37027		143.00	
						1.00	
144.00	Are provider based physicians' costs included in worksheet A?					Y	144.00
						1.00	
145.00	If costs for renal services are claimed on wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				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)						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)					08/26/2017	11/23/2017
						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

		Y/N	Date	
		1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
		Y/N	Legal Oper.	
		1.00	2.00	
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
		Y/N		
		1.00		
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Part A		Part B
		Y/N	Date	Y/N
		1.00	2.00	3.00
			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	08/22/2018	Y
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

Description		Y/N	Y/N	
0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N	N	20.00
		Y/N	Date	
		1.00	2.00	
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	Y		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N		27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N		31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N		33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N		35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	Y	12/31/2016	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.	BRENT	WILSON	41.00
42.00	Enter the employer/company name of the cost report preparer.	QUORUM HEALTH CORP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-221-3647	BRENT_WILSON@QUORUMHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet S-2
Part II
Date/Time Prepared:
9/25/2018 6:18 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet S-3
Part I
Date/Time Prepared:
9/25/2018 6:18 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					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	80	29,200	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)		80	29,200	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	18	6,570	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		98	35,770	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		98				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: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet S-3
Part I
Date/Time Prepared:
9/25/2018 6:18 pm

Component	I/P Days / O/P visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	4,820	2,314	9,951			1.00
2.00 HMO and other (see instructions)	778	1,145				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	3			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)	4,820	2,314	9,954			7.00
8.00 INTENSIVE CARE UNIT	827	36	1,671			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		504	1,468			13.00
14.00 Total (see instructions)	5,647	2,854	13,093	0.00	351.70	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	351.70	27.00
28.00 Observation Bed Days		0	2,442			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	590			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

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,636	1,147	4,142	1.00
2.00 HMO and other (see instructions)			0	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,636	1,147	4,142	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

	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	22,643,896	0	22,643,896	731,529.00	30.95 1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00 2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00 3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00 4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00 4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00 5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00 6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00 7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00 7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00 8.00
9.00	SNF	44.00	0	0	0	0.00	0.00 9.00
10.00	Excluded area salaries (see instructions)		92,629	8,549	101,178	733.00	138.03 10.00
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		921,309	0	921,309	17,847.00	51.62 11.00
12.00	Contract labor: Top level management and other management and administrative services		7,600	0	7,600	80.00	95.00 12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00 13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00 14.00
14.01	Home office salaries		646,458	0	646,458	8,822.00	73.28 14.01
14.02	Related organization salaries		0	0	0	0.00	0.00 14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00 15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		5,504,197	0	5,504,197		
18.00	Wage-related costs (other) (see instructions)		130,567	0	130,567		
19.00	Excluded areas		5,103	0	5,103		
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	258,949	0	258,949	8,080.00	32.05 26.00
27.00	Administrative & General	5.00	2,661,553	-84,086	2,577,467	91,474.00	28.18 27.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet S-3
Part II
Date/Time Prepared:
9/25/2018 6:18 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)	0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	369,396	0	369,396	14,305.00	25.82
31.00	Laundry & Linen Service	8.00	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,312,317	0	1,312,317	33,967.00	38.64
39.00	Central Services and Supply	14.00	242,764	0	242,764	12,686.00	19.14
40.00	Pharmacy	15.00	1,058,614	0	1,058,614	25,581.00	41.38
41.00	Medical Records & Medical Records Library	16.00	296,759	0	296,759	14,515.00	20.44
42.00	Social Service	17.00	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet S-3
Part III
Date/Time Prepared:
9/25/2018 6:18 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	22,643,896	0	22,643,896	731,529.00	30.95	1.00
2.00	Excluded area salaries (see instructions)	92,629	8,549	101,178	733.00	138.03	2.00
3.00	Subtotal salaries (line 1 minus line 2)	22,551,267	-8,549	22,542,718	730,796.00	30.85	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,575,367	0	1,575,367	26,749.00	58.89	4.00
5.00	Subtotal wage-related costs (see inst.)	5,634,764	0	5,634,764	0.00	25.00	5.00
6.00	Total (sum of lines 3 thru 5)	29,761,398	-8,549	29,752,849	757,545.00	39.28	6.00
7.00	Total overhead cost (see instructions)	6,200,352	-84,086	6,116,266	200,608.00	30.49	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet S-3
Part IV
Date/Time Prepared:
9/25/2018 6:18 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	310,705	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	3,017,954	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	25,194	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	17,577	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	-935	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	7,962	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	241,445	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	1,317,477	17.00
18.00	Medicare Taxes - Employers Portion Only	308,120	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	186,983	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5,432,482	24.00
Part B - Other than Core Related Cost			
25.00	OTHER BENEFITS AND EE RELOCATION	130,567	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet S-3
Part V
Date/Time Prepared:
9/25/2018 6:18 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	921,309	5,432,482	1.00
2.00	Hospital	921,309	5,432,482	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

		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)	0.100006	1.00
Medicaid (see instructions for each line)			
2.00	Net revenue from Medicaid	5,951,871	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	5,457,850	5.00
6.00	Medicaid charges	142,733,297	6.00
7.00	Medicaid cost (line 1 times line 6)	14,274,186	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)	2,864,465	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)	2,864,465	19.00
		Uninsured patients	Insured patients
		1.00	2.00
		Total (col. 1 + col. 2)	
		3.00	
Uncompensated Care (see instructions for each line)			
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	8,520,822	91,573
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	852,133	91,573
22.00	Payments received from patients for amounts previously written off as charity care	29,057	1,865
23.00	Cost of charity care (line 21 minus line 22)	823,076	89,708
		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)	5,368,567	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	468,837	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	721,288	27.01
28.00	Non-Medicare bad debt expense (see instructions)	4,647,279	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	717,207	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,629,991	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,494,456	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0184

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

Worksheet A

Date/Time Prepared:
9/25/2018 6:18 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 CAP REL COSTS-BLDG & FIXT		1,334,422	1,334,422	1,188,269	2,522,691	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		3,095,030	3,095,030	1,012,206	4,107,236	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	258,949	119,654	378,603	3,750,469	4,129,072	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	2,661,553	17,865,719	20,527,272	-5,403,248	15,124,024	5.00
7.00	00700 OPERATION OF PLANT	369,396	2,004,803	2,374,199	0	2,374,199	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	269,325	269,325	0	269,325	8.00
9.00	00900 HOUSEKEEPING	0	1,187,392	1,187,392	-740	1,186,652	9.00
10.00	01000 DIETARY	0	1,426,898	1,426,898	-402,111	1,024,787	10.00
11.00	01100 CAFETERIA	0	0	0	402,111	402,111	11.00
13.00	01300 NURSING ADMINISTRATION	1,312,317	224,933	1,537,250	-41,684	1,495,566	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	242,764	7,663,700	7,906,464	-3,435,635	4,470,829	14.00
15.00	01500 PHARMACY	1,058,614	2,800,943	3,859,557	-2,628,224	1,231,333	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	296,759	727,718	1,024,477	0	1,024,477	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	4,019,105	3,024,589	7,043,694	-555,933	6,487,761	30.00
31.00	03100 INTENSIVE CARE UNIT	1,313,907	932,643	2,246,550	-2,318	2,244,232	31.00
43.00	04300 NURSERY	255,850	59,773	315,623	343,672	659,295	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,765,492	3,024,493	4,789,985	149,232	4,939,217	50.00
51.00	05100 RECOVERY ROOM	442,902	42,266	485,168	-485,168	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	957,604	238,710	1,196,314	184,663	1,380,977	52.00
53.00	05300 ANESTHESIOLOGY	0	3,945,042	3,945,042	0	3,945,042	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,373,508	1,143,643	2,517,151	-242,673	2,274,478	54.00
54.01	05401 ULTRASOUND	197,168	33,833	231,001	-14,967	216,034	54.01
56.00	05600 RADIOISOTOPE	139,365	269,109	408,474	0	408,474	56.00
57.00	05700 CT SCAN	347,155	68,142	415,297	0	415,297	57.00
58.00	05800 MRI	94,249	10,674	104,923	0	104,923	58.00
60.00	06000 LABORATORY	1,148,917	2,042,066	3,190,983	-494,749	2,696,234	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	447,210	447,210	62.00
65.00	06500 RESPIRATORY THERAPY	524,993	231,514	756,507	-103,336	653,171	65.00
66.00	06600 PHYSICAL THERAPY	610,962	143,194	754,156	-38,324	715,832	66.00
67.00	06700 OCCUPATIONAL THERAPY	112,716	9,727	122,443	0	122,443	67.00
68.00	06800 SPEECH PATHOLOGY	113,399	9,375	122,774	0	122,774	68.00
69.00	06900 ELECTROCARDIOLOGY	1,204,558	1,479,311	2,683,869	-39,470	2,644,399	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	923,781	923,781	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,563,100	2,563,100	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	2,540,491	2,540,491	73.00
74.00	07400 RENAL DIALYSIS	0	236,977	236,977	0	236,977	74.00
76.00	03020 ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610 SLEEP LAB	0	229,204	229,204	0	229,204	76.01
76.03	03951 WOUND CARE	187,103	138,856	325,959	-23,128	302,831	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	1,541,962	2,555,162	4,097,124	233,304	4,330,428	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	75,537	177,915	253,452	-253,452	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	22,626,804	58,766,755	81,393,559	-426,652	80,966,907	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	-12,208	-12,208	0	-12,208	192.00
193.00	19300 NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301 SENIOR CIRCLE	17,092	1,303	18,395	0	18,395	193.01
194.00	07950 OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953 MARKETING	0	0	0	426,652	426,652	194.01
194.02	07952 NON ALLOWABLE MEALS	0	0	0	0	0	194.02
200.00	TOTAL (SUM OF LINES 118 through 199)	22,643,896	58,755,850	81,399,746	0	81,399,746	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0184

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

Worksheet A

Date/Time Prepared:
9/25/2018 6:18 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	616,618	3,139,309	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-777,601	3,329,635	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-5,319	4,123,753	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-5,736,519	9,387,505	5.00
7.00	00700	OPERATION OF PLANT	-14,832	2,359,367	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	269,325	8.00
9.00	00900	HOUSEKEEPING	0	1,186,652	9.00
10.00	01000	DIETARY	0	1,024,787	10.00
11.00	01100	CAFETERIA	-238,123	163,988	11.00
13.00	01300	NURSING ADMINISTRATION	-808	1,494,758	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,470,829	14.00
15.00	01500	PHARMACY	0	1,231,333	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-921	1,023,556	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,567,507	4,920,254	30.00
31.00	03100	INTENSIVE CARE UNIT	-624,000	1,620,232	31.00
43.00	04300	NURSERY	0	659,295	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-216,276	4,722,941	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,380,977	52.00
53.00	05300	ANESTHESIOLOGY	-3,762,942	182,100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-22,000	2,252,478	54.00
54.01	05401	ULTRASOUND	0	216,034	54.01
56.00	05600	RADIOISOTOPE	0	408,474	56.00
57.00	05700	CT SCAN	0	415,297	57.00
58.00	05800	MRI	0	104,923	58.00
60.00	06000	LABORATORY	0	2,696,234	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	447,210	62.00
65.00	06500	RESPIRATORY THERAPY	0	653,171	65.00
66.00	06600	PHYSICAL THERAPY	0	715,832	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	122,443	67.00
68.00	06800	SPEECH PATHOLOGY	0	122,774	68.00
69.00	06900	ELECTROCARDIOLOGY	-202,793	2,441,606	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	923,781	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,563,100	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,540,491	73.00
74.00	07400	RENAL DIALYSIS	0	236,977	74.00
76.00	03020	ACUPUNCTURE	0	0	76.00
76.01	03610	SLEEP LAB	-210,206	18,998	76.01
76.03	03951	WOUND CARE	-29,768	273,063	76.03
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-1,909,865	2,420,563	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		-14,702,862	66,264,045	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	-12,208	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	SENIOR CIRCLE	0	18,395	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	194.00
194.01	07953	MARKETING	0	426,652	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	194.02
200.00	TOTAL (SUM OF LINES 118 through 199)		-14,702,862	66,696,884	200.00

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - EMPLOYEE BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,750,469		1.00
	0		0	3,750,469		
B - OXYGEN COSTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	44,822		1.00
2.00		0.00	0	0		2.00
	0		0	44,822		
C - RENTAL AND LEASES						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	993,066		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,007,311		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
	0		0	2,000,377		
D - OTHER CAPITAL COSTS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	78,492		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	116,711		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,895		3.00
	0		0	200,098		
E - MARKETING DEPARTMENT						
1.00	MARKETING	194.01	84,086	342,566		1.00
	0		84,086	342,566		
F - MEDICAL SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	878,959		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,563,100		2.00
	0		0	3,442,059		
G - DRUGS/IV SOLUTIONS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,540,491		1.00
	0		0	2,540,491		
H - LABOR AND DELIVERY COSTS						
1.00	NURSERY	43.00	207,925	135,747		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	211,268		2.00
	0		207,925	347,015		
K - MISCELLANEOUS DEPARTMENTS						
1.00	OPERATING ROOM	50.00	442,902	42,266		1.00
2.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	52,393	394,817		2.00
3.00	EMERGENCY	91.00	75,537	177,915		3.00
	0		570,832	614,998		
M - PORTION OF DIETARY COST TO CAFETERIA						
1.00	CAFETERIA	11.00	0	402,111		1.00
	0		0	402,111		
500.00	Grand Total: Increases		862,843	13,685,006		500.00

		Decreases					3/23/2010 0:10 pm	
		Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
		6.00	7.00	8.00	9.00	10.00		
A - EMPLOYEE BENEFITS								
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,750,469	0		1.00	
	0		0	3,750,469				
B - OXYGEN COSTS								
1.00	RESPIRATORY THERAPY	65.00	0	30,904	0		1.00	
2.00	WOUND CARE	76.03	0	13,918	0		2.00	
	0		0	44,822				
C - RENTAL AND LEASES								
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,026,029	10		1.00	
2.00	HOUSEKEEPING	9.00	0	740	10		2.00	
3.00	NURSING ADMINISTRATION	13.00	0	41,684	0		3.00	
4.00	PHARMACY	15.00	0	87,733	0		4.00	
5.00	ADULTS & PEDIATRICS	30.00	0	27,598	0		5.00	
6.00	INTENSIVE CARE UNIT	31.00	0	2,318	0		6.00	
7.00	OPERATING ROOM	50.00	0	335,936	0		7.00	
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	242,673	0		8.00	
9.00	ULTRASOUND	54.01	0	14,967	0		9.00	
10.00	LABORATORY	60.00	0	47,539	0		10.00	
11.00	RESPIRATORY THERAPY	65.00	0	72,432	0		11.00	
12.00	PHYSICAL THERAPY	66.00	0	38,324	0		12.00	
13.00	ELECTROCARDIOLOGY	69.00	0	33,046	0		13.00	
14.00	WOUND CARE	76.03	0	9,210	0		14.00	
15.00	EMERGENCY	91.00	0	20,148	0		15.00	
	0		0	2,000,377				
D - OTHER CAPITAL COSTS								
1.00	ADMINISTRATIVE & GENERAL	5.00	0	200,098	12		1.00	
2.00		0.00	0	0	13		2.00	
3.00		0.00	0	0	12		3.00	
	0		0	200,098				
E - MARKETING DEPARTMENT								
1.00	ADMINISTRATIVE & GENERAL	5.00	84,086	342,566	0		1.00	
	0		84,086	342,566				
F - MEDICAL SUPPLIES								
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	3,435,635	0		1.00	
2.00	ELECTROCARDIOLOGY	69.00	0	6,424	0		2.00	
	0		0	3,442,059				
G - DRUGS/IV SOLUTIONS								
1.00	PHARMACY	15.00	0	2,540,491	0		1.00	
	0		0	2,540,491				
H - LABOR AND DELIVERY COSTS								
1.00	ADULTS & PEDIATRICS	30.00	181,320	347,015	0		1.00	
2.00	DELIVERY ROOM & LABOR ROOM	52.00	26,605	0	0		2.00	
	0		207,925	347,015				
K - MISCELLANEOUS DEPARTMENTS								
1.00	RECOVERY ROOM	51.00	442,902	42,266	0		1.00	
2.00	LABORATORY	60.00	52,393	394,817	0		2.00	
3.00	AMBULANCE SERVICES	95.00	75,537	177,915	0		3.00	
	0		570,832	614,998				
M - PORTION OF DIETARY COST TO CAFETERIA								
1.00	DIETARY	10.00	0	402,111	0		1.00	
	0		0	402,111				
500.00	Grand Total: Decreases		862,843	13,685,006			500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet A-7
Part I
Date/Time Prepared:
9/25/2018 6:18 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
			1.00	2.00	3.00			4.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	1,393,860	0	0	0	0	1.00	
2.00	Land Improvements	569,343	0	0	0	8,250	2.00	
3.00	Buildings and Fixtures	46,993,994	13,270	0	13,270	0	3.00	
4.00	Building Improvements	6,451,150	326,512	0	326,512	137,676	4.00	
5.00	Fixed Equipment	2,361,702	114,135	0	114,135	9,840	5.00	
6.00	Movable Equipment	27,024,773	606,866	0	606,866	710,969	6.00	
7.00	HIT designated Assets	6,547,163	8,680	0	8,680	36,340	7.00	
8.00	Subtotal (sum of lines 1-7)	91,341,985	1,069,463	0	1,069,463	903,075	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	91,341,985	1,069,463	0	1,069,463	903,075	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	1,393,860	0					1.00
2.00	Land Improvements	561,093	0					
3.00	Buildings and Fixtures	47,007,264	0					
4.00	Building Improvements	6,639,986	0					
5.00	Fixed Equipment	2,465,997	0					
6.00	Movable Equipment	26,920,670	0					
7.00	HIT designated Assets	6,519,503	0					
8.00	Subtotal (sum of lines 1-7)	91,508,373	0					
9.00	Reconciling Items	0	0					
10.00	Total (line 8 minus line 9)	91,508,373	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet A-7
Part II
Date/Time Prepared:
9/25/2018 6:18 pm

3/23/2016 6:16 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	1,334,422	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,095,030	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,429,452	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	1,334,422				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,095,030				2.00
3.00	Total (sum of lines 1-2)	0	4,429,452				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet A-7
Part III
Date/Time Prepared:
9/25/2018 6:18 pm

9/23/2018 6:16 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	55,602,203	0	55,602,203	0.607619	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	35,906,170	0	35,906,170	0.392381	0	2.00
3.00	Total (sum of lines 1-2)	91,508,373	0	91,508,373	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	1,874,315	965,737	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,302,265	1,007,311	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,176,580	1,973,048	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	104,054	78,492	116,711	0	3,139,309	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	15,164	4,895	0	0	3,329,635	2.00
3.00	Total (sum of lines 1-2)	119,218	83,387	116,711	0	6,468,944	3.00

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A		Wkst. A-7 Ref.	
				To/From Which the Amount is to be Adjusted			
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0 CAP REL COSTS-BLDG & FIXT	1.00		0 1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0 CAP REL COSTS-MVBLE EQUIP	2.00		0 2.00
3.00	Investment income - other (chapter 2)			0	0.00		0 3.00
4.00	Trade, quantity, and time discounts (chapter 8)			0	0.00		0 4.00
5.00	Refunds and rebates of expenses (chapter 8)			0	0.00		0 5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-27,329	CAP REL COSTS-BLDG & FIXT	1.00	10	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-40,228	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	-8,492,153				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	-896,160				0 12.00
13.00	Laundry and linen service			0	0.00		0 13.00
14.00	Cafeteria-employees and guests	B	-238,123	CAFETERIA	11.00		0 14.00
15.00	Rental of quarters to employee and others			0	0.00		0 15.00
16.00	Sale of medical and surgical supplies to other than patients			0	0.00		0 16.00
17.00	Sale of drugs to other than patients			0	0.00		0 17.00
18.00	Sale of medical records and abstracts	B	-921	MEDICAL RECORDS & LIBRARY	16.00		0 18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)	B	-808	NURSING ADMINISTRATION	13.00		0 19.00
20.00	Vending machines	B	-9,676	ADMINISTRATIVE & GENERAL	5.00		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	A	539,893	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-781,625	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist			0 *** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant			0	0.00		0 29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0 OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0 ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0 SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0	0.00		0 32.00
33.00	MISCELLANEOUS REVENUE	B	-6,596	ADMINISTRATIVE & GENERAL	5.00		0 33.00

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #	Wkst. A-7 Ref.	
				Cost Center				
		1.00	2.00	3.00		4.00	5.00	
33.02	PATIENT PHONE SALARIES AND WAGES	A	-21,651	ADMINISTRATIVE & GENERAL		5.00		0 33.02
33.03	PATIENT PHONE BENEFIT EXPENSE	A	-5,319	EMPLOYEE BENEFITS DEPARTMENT		4.00		0 33.03
33.04	PATIENT PHONE DEPRECIATION EXPENSE	A	-6,938	CAP REL COSTS-MVBLE EQUIP		2.00		9 33.04
33.05	PATIENT TV DEPRECIATION EXPENSE	A	-4,202	CAP REL COSTS-MVBLE EQUIP		2.00		9 33.05
33.06	MARKETING EXPENSES	A	-333,137	ADMINISTRATIVE & GENERAL		5.00		0 33.06
33.07	EMPLOYEE GIFTS	A	-2,310	ADMINISTRATIVE & GENERAL		5.00		0 33.07
33.08	PHYSICIAN RECRUITING	A	-128,683	ADMINISTRATIVE & GENERAL		5.00		0 33.08
33.09	LOBBYING EXPENSE	A	-31,408	ADMINISTRATIVE & GENERAL		5.00		0 33.09
33.10	CHARITABLE CONTRIBUTIONS	A	-13,543	ADMINISTRATIVE & GENERAL		5.00		0 33.10
33.11	GIFT SHOP	A	-844	ADMINISTRATIVE & GENERAL		5.00		0 33.11
33.12	ILLINOIS PROVIDER TAX	A	-4,113,580	ADMINISTRATIVE & GENERAL		5.00		0 33.12
33.13	CRNA COST	A	-54,142	ANESTHESIOLOGY		53.00		0 33.13
33.15	PENALTIES/LATE CHARGES	A	-11,056	ADMINISTRATIVE & GENERAL		5.00		0 33.15
33.16	SPECIAL EVENTS	A	-4,647	ADMINISTRATIVE & GENERAL		5.00		0 33.16
33.18	LATE CHARGES	A	-2,844	ADMINISTRATIVE & GENERAL		5.00		0 33.18
33.19	PATIENT TV CABLE EXPENSE	A	-14,832	OPERATION OF PLANT		7.00		0 33.19
33.20	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00		0 33.20
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-14,702,862					50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0184

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

Worksheet A-8-1

Date/Time Prepared:
9/25/2018 6:18 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	DIRECT ALLOCATION - QHR COST	73,223	0 1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	POOLED ALLOCATION OF NON-CAP	544,619	0 2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	104,054	0 3.00
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	15,164	0 4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL FUNCTIONAL ALLOC	765,621	0 4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	23,440	707,273 4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE	0	1,715,008 4.03
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.		1,526,121	2,422,281	5.00

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

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

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

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

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

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

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

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

Provider CCN: 14-0184

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

Worksheet A-8-1

Date/Time Prepared:
9/25/2018 6:18 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	73,223	0		1.00
2.00	544,619	0		2.00
3.00	104,054	11		3.00
4.00	15,164	11		4.00
4.01	765,621	0		4.01
4.02	-683,833	0		4.02
4.03	-1,715,008	0		4.03
5.00	-896,160			5.00

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

	Related Organization(s) and/or Home Office	
	Type of Business	
	6.00	

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

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

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

6.00	HOSPITAL CORPOR		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet A-8-2
Date/Time Prepared:
9/25/2018 6:18 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	938	938	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,567,507	1,567,507	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	624,000	624,000	0	0	0	3.00
4.00	50.00	OPERATING ROOM	216,276	216,276	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	3,708,800	3,708,800	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	22,000	22,000	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	202,793	202,793	0	0	0	7.00
8.00	76.01	SLEEP LAB	210,206	210,206	0	0	0	8.00
9.00	76.03	WOUND CARE	29,768	29,768	0	0	0	9.00
10.00	91.00	EMERGENCY	1,909,865	1,909,865	0	0	0	10.00
200.00			8,492,153	8,492,153	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	7.00
8.00	76.01	SLEEP LAB	0	0	0	0	0	8.00
9.00	76.03	WOUND CARE	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	938		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,567,507		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	624,000		3.00
4.00	50.00	OPERATING ROOM	0	0	0	216,276		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	3,708,800		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	22,000		6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	202,793		7.00
8.00	76.01	SLEEP LAB	0	0	0	210,206		8.00
9.00	76.03	WOUND CARE	0	0	0	29,768		9.00
10.00	91.00	EMERGENCY	0	0	0	1,909,865		10.00
200.00			0	0	0	8,492,153		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet B
Part I
Date/Time Prepared:
9/25/2018 6:18 pm

Cost Center Description		Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	MOVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,139,309	3,139,309			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,329,635	3,329,635			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,123,753	16,112	17,089	4,156,954	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,387,505	318,048	337,331	478,643	10,521,527
7.00	00700	OPERATION OF PLANT	2,359,367	682,301	723,667	68,598	3,833,933
8.00	00800	LAUNDRY & LINEN SERVICE	269,325	6,616	7,017	0	282,958
9.00	00900	HOUSEKEEPING	1,186,652	17,940	19,027	0	1,223,619
10.00	01000	DIETARY	1,024,787	48,884	51,848	0	1,125,519
11.00	01100	CAFETERIA	163,988	55,247	58,596	0	277,831
13.00	01300	NURSING ADMINISTRATION	1,494,758	76,161	80,778	243,701	1,895,398
14.00	01400	CENTRAL SERVICES & SUPPLY	4,470,829	31,091	32,976	45,082	4,579,978
15.00	01500	PHARMACY	1,231,333	28,277	29,991	196,588	1,486,189
16.00	01600	MEDICAL RECORDS & LIBRARY	1,023,556	45,750	48,524	55,109	1,172,939
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,920,254	493,405	523,319	712,691	6,649,669
31.00	03100	INTENSIVE CARE UNIT	1,620,232	163,312	173,214	243,996	2,200,754
43.00	04300	NURSERY	659,295	26,490	28,096	86,124	800,005
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,722,941	273,819	290,420	410,105	5,697,285
51.00	05100	RECOVERY ROOM	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,380,977	63,890	67,763	172,889	1,685,519
53.00	05300	ANESTHESIOLOGY	182,100	7,936	8,417	0	198,453
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,252,478	97,235	103,130	255,065	2,707,908
54.01	05401	ULTRASOUND	216,034	27,823	29,510	36,615	309,982
56.00	05600	RADIOISOTOPE	408,474	9,217	9,775	25,880	453,346
57.00	05700	CT SCAN	415,297	16,032	17,004	64,468	512,801
58.00	05800	MRI	104,923	17,033	18,065	17,502	157,523
60.00	06000	LABORATORY	2,696,234	63,196	67,028	203,628	3,030,086
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	447,210	3,361	3,565	9,730	463,866
65.00	06500	RESPIRATORY THERAPY	653,171	14,472	15,349	97,493	780,485
66.00	06600	PHYSICAL THERAPY	715,832	87,298	92,591	113,457	1,009,178
67.00	06700	OCCUPATIONAL THERAPY	122,443	2,201	2,334	20,932	147,910
68.00	06800	SPEECH PATHOLOGY	122,774	1,240	1,316	21,059	146,389
69.00	06900	ELECTROCARDIOLOGY	2,441,606	55,887	59,275	223,690	2,780,458
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	923,781	0	0	0	923,781
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,563,100	0	0	0	2,563,100
73.00	07300	DRUGS CHARGED TO PATIENTS	2,540,491	0	0	0	2,540,491
74.00	07400	RENAL DIALYSIS	236,977	4,455	4,725	0	246,157
76.00	03020	ACUPUNCTURE	0	0	0	0	0
76.01	03610	SLEEP LAB	18,998	31,425	33,330	0	83,753
76.03	03951	WOUND CARE	273,063	37,534	39,809	34,746	385,152
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	2,420,563	127,219	134,932	300,374	2,983,088
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	66,264,045	2,950,907	3,129,811	4,138,165	65,857,030
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,017	9,563	0	18,580
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-12,208	176,064	186,738	0	350,594
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.01	19301	SENIOR CIRCLE	18,395	3,321	3,523	3,174	28,413
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0
194.01	07953	MARKETING	426,652	0	0	15,615	442,267
194.02	07952	NON ALLOWABLE MEALS	0	0	0	0	0
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	66,696,884	3,139,309	3,329,635	4,156,954	66,696,884

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet B
Part I
Date/Time Prepared:
9/25/2018 6:18 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	10,521,527					5.00
7.00	00700 OPERATION OF PLANT	718,088	4,552,021				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	52,997	14,186	350,141			8.00
9.00	00900 HOUSEKEEPING	229,181	38,468	0	1,491,268		9.00
10.00	01000 DIETARY	210,807	104,823	0	34,742	1,475,891	10.00
11.00	01100 CAFETERIA	52,037	118,465	0	39,264	1,045,157	11.00
13.00	01300 NURSING ADMINISTRATION	355,004	163,312	0	54,128	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	857,821	66,669	0	22,097	0	14.00
15.00	01500 PHARMACY	278,360	60,634	0	20,097	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	219,689	98,101	0	32,515	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	1,245,466	1,058,009	138,297	350,668	293,796	30.00
31.00	03100 INTENSIVE CARE UNIT	412,197	350,191	36,562	116,067	43,222	31.00
43.00	04300 NURSERY	149,839	56,802	0	18,826	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,067,090	587,150	31,869	194,605	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	315,694	136,999	0	45,407	0	52.00
53.00	05300 ANESTHESIOLOGY	37,170	17,018	0	5,640	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	507,186	208,501	51,516	69,106	0	54.00
54.01	05401 ULTRASOUND	58,059	59,662	0	19,774	0	54.01
56.00	05600 RADIOISOTOPE	84,911	19,763	0	6,550	0	56.00
57.00	05700 CT SCAN	96,047	34,378	0	11,394	0	57.00
58.00	05800 MRI	29,504	36,523	0	12,105	0	58.00
60.00	06000 LABORATORY	567,529	135,512	0	44,914	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	86,881	7,207	0	2,389	0	62.00
65.00	06500 RESPIRATORY THERAPY	146,183	31,032	0	10,285	0	65.00
66.00	06600 PHYSICAL THERAPY	189,017	187,194	15,515	62,043	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	27,703	4,719	0	1,564	0	67.00
68.00	06800 SPEECH PATHOLOGY	27,418	2,660	0	882	0	68.00
69.00	06900 ELECTROCARDIOLOGY	520,774	119,838	49,590	39,719	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	173,022	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	480,064	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	475,829	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	46,105	9,553	0	3,166	0	74.00
76.00	03020 ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610 SLEEP LAB	15,687	67,384	2,557	22,334	0	76.01
76.03	03951 WOUND CARE	72,138	80,483	35	26,675	0	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	558,726	272,796	24,200	90,415	12,998	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	10,364,223	4,148,032	350,141	1,357,371	1,395,173	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,480	19,334	0	6,408	0	190.00
191.00	19100 RESEARCH	0	0	0	0	0	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	65,666	377,533	0	125,129	80,718	192.00
193.00	19300 NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301 SENIOR CIRCLE	5,322	7,122	0	2,360	0	193.01
194.00	07950 OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953 MARKETING	82,836	0	0	0	0	194.01
194.02	07952 NON ALLOWABLE MEALS	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)	10,521,527	4,552,021	350,141	1,491,268	1,475,891	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet B
Part I
Date/Time Prepared:
9/25/2018 6:18 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DIETARY						10.00
11.00	01100 CAFETERIA	1,532,754					11.00
13.00	01300 NURSING ADMINISTRATION	84,287	2,552,129				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	31,485	0	5,558,050			14.00
15.00	01500 PHARMACY	63,486	0	18,083	1,926,849		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	36,027	0	5,227	0	1,564,498	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	277,844	586,436	199,719	0	105,489	30.00
31.00	03100 INTENSIVE CARE UNIT	75,254	232,211	80,497	0	21,417	31.00
43.00	04300 NURSERY	50,737	120,035	19,386	0	7,484	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	164,651	390,296	1,121,940	0	252,326	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	98,326	218,292	4,815	0	10,566	52.00
53.00	05300 ANESTHESIOLOGY	0	0	83,029	0	52,655	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	105,397	242,744	25,267	0	38,496	54.00
54.01	05401 ULTRASOUND	13,471	34,846	1,153	0	13,466	54.01
56.00	05600 RADIOISOTOPE	8,155	24,630	1,833	0	40,065	56.00
57.00	05700 CT SCAN	28,388	61,354	18,855	0	99,297	57.00
58.00	05800 MRI	6,091	16,657	335	0	19,598	58.00
60.00	06000 LABORATORY	138,896	0	334,725	0	247,429	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	4,903	0	12,252	0	8,302	62.00
65.00	06500 RESPIRATORY THERAPY	49,550	92,784	35,164	0	39,153	65.00
66.00	06600 PHYSICAL THERAPY	45,318	0	7,074	0	26,022	66.00
67.00	06700 OCCUPATIONAL THERAPY	8,000	0	0	0	6,292	67.00
68.00	06800 SPEECH PATHOLOGY	6,194	0	0	0	3,177	68.00
69.00	06900 ELECTROCARDIOLOGY	97,449	212,885	181,200	0	172,851	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,591,345	0	35,979	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	1,612,014	0	107,764	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	1,926,849	106,724	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	3,836	74.00
76.00	03020 ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610 SLEEP LAB	0	0	7,839	0	5,041	76.01
76.03	03951 WOUND CARE	16,672	33,067	11,856	0	2,829	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	114,998	285,892	182,503	0	138,240	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,525,579	2,552,129	5,556,111	1,926,849	1,564,498	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
193.00	19300 NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301 SENIOR CIRCLE	1,807	0	368	0	0	193.01
194.00	07950 OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953 MARKETING	5,368	0	1,571	0	0	194.01
194.02	07952 NON ALLOWABLE MEALS	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)	1,532,754	2,552,129	5,558,050	1,926,849	1,564,498	202.00

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	10,905,393	0	10,905,393
31.00	03100	INTENSIVE CARE UNIT	3,568,372	0	3,568,372
43.00	04300	NURSERY	1,223,114	0	1,223,114
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	9,507,212	0	9,507,212
51.00	05100	RECOVERY ROOM	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,515,618	0	2,515,618
53.00	05300	ANESTHESIOLOGY	393,965	0	393,965
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,956,121	0	3,956,121
54.01	05401	ULTRASOUND	510,413	0	510,413
56.00	05600	RADIOISOTOPE	639,253	0	639,253
57.00	05700	CT SCAN	862,514	0	862,514
58.00	05800	MRI	278,336	0	278,336
60.00	06000	LABORATORY	4,499,091	0	4,499,091
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	585,800	0	585,800
65.00	06500	RESPIRATORY THERAPY	1,184,636	0	1,184,636
66.00	06600	PHYSICAL THERAPY	1,541,361	0	1,541,361
67.00	06700	OCCUPATIONAL THERAPY	196,188	0	196,188
68.00	06800	SPEECH PATHOLOGY	186,720	0	186,720
69.00	06900	ELECTROCARDIOLOGY	4,174,764	0	4,174,764
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,724,127	0	2,724,127
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,762,942	0	4,762,942
73.00	07300	DRUGS CHARGED TO PATIENTS	5,049,893	0	5,049,893
74.00	07400	RENAL DIALYSIS	308,817	0	308,817
76.00	03020	ACUPUNCTURE	0	0	0
76.01	03610	SLEEP LAB	204,595	0	204,595
76.03	03951	WOUND CARE	628,907	0	628,907
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	4,663,856	0	4,663,856
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	65,072,008	0	65,072,008
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	47,802	0	47,802
191.00	19100	RESEARCH	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	999,640	0	999,640
193.00	19300	NONPAID WORKERS	0	0	0
193.01	19301	SENIOR CIRCLE	45,392	0	45,392
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0
194.01	07953	MARKETING	532,042	0	532,042
194.02	07952	NON ALLOWABLE MEALS	0	0	0
200.00		Cross Foot Adjustments	0	0	0
201.00		Negative Cost Centers	0	0	0
202.00		TOTAL (sum lines 118 through 201)	66,696,884	0	66,696,884

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	0	318,048	337,331	655,379	3,822	5.00
7.00	00700	0	682,301	723,667	1,405,968	548	7.00
8.00	00800	0	6,616	7,017	13,633	0	8.00
9.00	00900	0	17,940	19,027	36,967	0	9.00
10.00	01000	0	48,884	51,848	100,732	0	10.00
11.00	01100	0	55,247	58,596	113,843	0	11.00
13.00	01300	0	76,161	80,778	156,939	1,946	13.00
14.00	01400	0	31,091	32,976	64,067	360	14.00
15.00	01500	0	28,277	29,991	58,268	1,570	15.00
16.00	01600	0	45,750	48,524	94,274	440	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	493,405	523,319	1,016,724	5,695	30.00
31.00	03100	0	163,312	173,214	336,526	1,949	31.00
43.00	04300	0	26,490	28,096	54,586	688	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	273,819	290,420	564,239	3,275	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	63,890	67,763	131,653	1,381	52.00
53.00	05300	0	7,936	8,417	16,353	0	53.00
54.00	05400	0	97,235	103,130	200,365	2,037	54.00
54.01	05401	0	27,823	29,510	57,333	292	54.01
56.00	05600	0	9,217	9,775	18,992	207	56.00
57.00	05700	0	16,032	17,004	33,036	515	57.00
58.00	05800	0	17,033	18,065	35,098	140	58.00
60.00	06000	0	63,196	67,028	130,224	1,626	60.00
62.00	06200	0	3,361	3,565	6,926	78	62.00
65.00	06500	0	14,472	15,349	29,821	779	65.00
66.00	06600	0	87,298	92,591	179,889	906	66.00
67.00	06700	0	2,201	2,334	4,535	167	67.00
68.00	06800	0	1,240	1,316	2,556	168	68.00
69.00	06900	0	55,887	59,275	115,162	1,786	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	4,455	4,725	9,180	0	74.00
76.00	03020	0	0	0	0	0	76.00
76.01	03610	0	31,425	33,330	64,755	0	76.01
76.03	03951	0	37,534	39,809	77,343	277	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	0	127,219	134,932	262,151	2,399	91.00
92.00	09200	0			0		92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
96.00	09600	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	2,950,907	3,129,811	6,080,718	33,051	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	9,017	9,563	18,580	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	176,064	186,738	362,802	0	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	3,321	3,523	6,844	25	193.01
194.00	07950	0	0	0	0	0	194.00
194.01	07953	0	0	0	0	125	194.01
194.02	07952	0	0	0	0	0	194.02
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	3,139,309	3,329,635	6,468,944	33,201	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet B
Part II
Date/Time Prepared:
9/25/2018 6:18 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	659,201					5.00
7.00	00700 OPERATION OF PLANT	44,991	1,451,507				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	3,321	4,524	21,478			8.00
9.00	00900 HOUSEKEEPING	14,359	12,266	0	63,592		9.00
10.00	01000 DIETARY	13,208	33,425	0	1,482	148,847	10.00
11.00	01100 CAFETERIA	3,260	37,775	0	1,674	105,406	11.00
13.00	01300 NURSING ADMINISTRATION	22,242	52,075	0	2,308	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	53,746	21,259	0	942	0	14.00
15.00	01500 PHARMACY	17,440	19,334	0	857	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	13,764	31,282	0	1,387	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	78,015	337,369	8,483	14,951	29,630	30.00
31.00	03100 INTENSIVE CARE UNIT	25,826	111,666	2,243	4,949	4,359	31.00
43.00	04300 NURSERY	9,388	18,112	0	803	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	66,858	187,225	1,955	8,299	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	19,780	43,685	0	1,936	0	52.00
53.00	05300 ANESTHESIOLOGY	2,329	5,426	0	241	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	31,777	66,485	3,160	2,947	0	54.00
54.01	05401 ULTRASOUND	3,638	19,024	0	843	0	54.01
56.00	05600 RADIOISOTOPE	5,320	6,302	0	279	0	56.00
57.00	05700 CT SCAN	6,018	10,962	0	486	0	57.00
58.00	05800 MRI	1,849	11,646	0	516	0	58.00
60.00	06000 LABORATORY	35,558	43,211	0	1,915	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	5,443	2,298	0	102	0	62.00
65.00	06500 RESPIRATORY THERAPY	9,159	9,895	0	439	0	65.00
66.00	06600 PHYSICAL THERAPY	11,843	59,691	952	2,646	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,736	1,505	0	67	0	67.00
68.00	06800 SPEECH PATHOLOGY	1,718	848	0	38	0	68.00
69.00	06900 ELECTROCARDIOLOGY	32,629	38,213	3,042	1,694	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10,841	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	30,078	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	29,813	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	2,889	3,046	0	135	0	74.00
76.00	03020 ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610 SLEEP LAB	983	21,487	157	952	0	76.01
76.03	03951 WOUND CARE	4,520	25,664	2	1,138	0	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	35,007	86,987	1,484	3,856	1,311	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	649,346	1,322,687	21,478	57,882	140,706	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	218	6,165	0	273	0	190.00
191.00	19100 RESEARCH	0	0	0	0	0	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	4,114	120,384	0	5,336	8,141	192.00
193.00	19300 NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301 SENIOR CIRCLE	333	2,271	0	101	0	193.01
194.00	07950 OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953 MARKETING	5,190	0	0	0	0	194.01
194.02	07952 NON ALLOWABLE MEALS	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)	659,201	1,451,507	21,478	63,592	148,847	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet B
Part II
Date/Time Prepared:
9/25/2018 6:18 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DIETARY						10.00
11.00	01100 CAFETERIA	261,958					11.00
13.00	01300 NURSING ADMINISTRATION	14,405	249,915				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	5,381	0	145,755			14.00
15.00	01500 PHARMACY	10,850	0	474	108,793		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	6,157	0	137	0	147,441	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	47,487	57,432	5,238	0	9,961	30.00
31.00	03100 INTENSIVE CARE UNIT	12,861	22,738	2,111	0	2,022	31.00
43.00	04300 NURSERY	8,671	11,754	508	0	707	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	28,140	38,218	29,423	0	23,537	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	16,805	21,375	126	0	998	52.00
53.00	05300 ANESTHESIOLOGY	0	0	2,177	0	4,972	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	18,013	23,770	663	0	3,635	54.00
54.01	05401 ULTRASOUND	2,302	3,412	30	0	1,272	54.01
56.00	05600 RADIOISOTOPE	1,394	2,412	48	0	3,783	56.00
57.00	05700 CT SCAN	4,852	6,008	494	0	9,376	57.00
58.00	05800 MRI	1,041	1,631	9	0	1,851	58.00
60.00	06000 LABORATORY	23,738	0	8,778	0	23,364	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	838	0	321	0	784	62.00
65.00	06500 RESPIRATORY THERAPY	8,468	9,086	922	0	3,697	65.00
66.00	06600 PHYSICAL THERAPY	7,745	0	186	0	2,457	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,367	0	0	0	594	67.00
68.00	06800 SPEECH PATHOLOGY	1,059	0	0	0	300	68.00
69.00	06900 ELECTROCARDIOLOGY	16,655	20,846	4,752	0	16,322	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	41,733	0	3,397	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	42,271	0	10,176	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	108,793	10,078	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	362	74.00
76.00	03020 ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610 SLEEP LAB	0	0	206	0	476	76.01
76.03	03951 WOUND CARE	2,849	3,238	311	0	267	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	19,654	27,995	4,786	0	13,053	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	260,732	249,915	145,704	108,793	147,441	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
193.00	19300 NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301 SENIOR CIRCLE	309	0	10	0	0	193.01
194.00	07950 OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953 MARKETING	917	0	41	0	0	194.01
194.02	07952 NON ALLOWABLE MEALS	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)	261,958	249,915	145,755	108,793	147,441	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet B
Part II
Date/Time Prepared:
9/25/2018 6:18 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,610,985	0	1,610,985
31.00	03100	INTENSIVE CARE UNIT	527,250	0	527,250
43.00	04300	NURSERY	105,217	0	105,217
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	951,169	0	951,169
51.00	05100	RECOVERY ROOM	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	237,739	0	237,739
53.00	05300	ANESTHESIOLOGY	31,498	0	31,498
54.00	05400	RADIOLOGY-DIAGNOSTIC	352,852	0	352,852
54.01	05401	ULTRASOUND	88,146	0	88,146
56.00	05600	RADIOISOTOPE	38,737	0	38,737
57.00	05700	CT SCAN	71,747	0	71,747
58.00	05800	MRI	53,781	0	53,781
60.00	06000	LABORATORY	268,414	0	268,414
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	16,790	0	16,790
65.00	06500	RESPIRATORY THERAPY	72,266	0	72,266
66.00	06600	PHYSICAL THERAPY	266,315	0	266,315
67.00	06700	OCCUPATIONAL THERAPY	9,971	0	9,971
68.00	06800	SPEECH PATHOLOGY	6,687	0	6,687
69.00	06900	ELECTROCARDIOLOGY	251,101	0	251,101
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	55,971	0	55,971
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	82,525	0	82,525
73.00	07300	DRUGS CHARGED TO PATIENTS	148,684	0	148,684
74.00	07400	RENAL DIALYSIS	15,612	0	15,612
76.00	03020	ACUPUNCTURE	0	0	0
76.01	03610	SLEEP LAB	89,016	0	89,016
76.03	03951	WOUND CARE	115,609	0	115,609
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	458,683	0	458,683
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,926,765	0	5,926,765
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	25,236	0	25,236
191.00	19100	RESEARCH	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	500,777	0	500,777
193.00	19300	NONPAID WORKERS	0	0	0
193.01	19301	SENIOR CIRCLE	9,893	0	9,893
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0
194.01	07953	MARKETING	6,273	0	6,273
194.02	07952	NON ALLOWABLE MEALS	0	0	0
200.00		Cross Foot Adjustments	0	0	0
201.00		Negative Cost Centers	0	0	0
202.00		TOTAL (sum lines 118 through 201)	6,468,944	0	6,468,944

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0184

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

Worksheet B-1

Date/Time Prepared:
9/25/2018 6:18 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	235,363					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		235,363				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,208	1,208	22,384,947			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	23,845	23,845	2,577,467	-10,521,527	56,175,357	5.00
7.00	00700	OPERATION OF PLANT	51,154	51,154	369,396	0	3,833,933	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	496	496	0	0	282,958	8.00
9.00	00900	HOUSEKEEPING	1,345	1,345	0	0	1,223,619	9.00
10.00	01000	DIETARY	3,665	3,665	0	0	1,125,519	10.00
11.00	01100	CAFETERIA	4,142	4,142	0	0	277,831	11.00
13.00	01300	NURSING ADMINISTRATION	5,710	5,710	1,312,317	0	1,895,398	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,331	2,331	242,764	0	4,579,978	14.00
15.00	01500	PHARMACY	2,120	2,120	1,058,614	0	1,486,189	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,430	3,430	296,759	0	1,172,939	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	36,992	36,992	3,837,785	0	6,649,669	30.00
31.00	03100	INTENSIVE CARE UNIT	12,244	12,244	1,313,907	0	2,200,754	31.00
43.00	04300	NURSERY	1,986	1,986	463,775	0	800,005	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	20,529	20,529	2,208,394	0	5,697,285	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,790	4,790	930,999	0	1,685,519	52.00
53.00	05300	ANESTHESIOLOGY	595	595	0	0	198,453	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,290	7,290	1,373,508	0	2,707,908	54.00
54.01	05401	ULTRASOUND	2,086	2,086	197,168	0	309,982	54.01
56.00	05600	RADIOISOTOPE	691	691	139,365	0	453,346	56.00
57.00	05700	CT SCAN	1,202	1,202	347,155	0	512,801	57.00
58.00	05800	MRI	1,277	1,277	94,249	0	157,523	58.00
60.00	06000	LABORATORY	4,738	4,738	1,096,524	0	3,030,086	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	252	252	52,393	0	463,866	62.00
65.00	06500	RESPIRATORY THERAPY	1,085	1,085	524,993	0	780,485	65.00
66.00	06600	PHYSICAL THERAPY	6,545	6,545	610,962	0	1,009,178	66.00
67.00	06700	OCCUPATIONAL THERAPY	165	165	112,716	0	147,910	67.00
68.00	06800	SPEECH PATHOLOGY	93	93	113,399	0	146,389	68.00
69.00	06900	ELECTROCARDIOLOGY	4,190	4,190	1,204,558	0	2,780,458	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	923,781	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,563,100	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,540,491	73.00
74.00	07400	RENAL DIALYSIS	334	334	0	0	246,157	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	2,356	2,356	0	0	83,753	76.01
76.03	03951	WOUND CARE	2,814	2,814	187,103	0	385,152	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	9,538	9,538	1,617,499	0	2,983,088	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	221,238	221,238	22,283,769	-10,521,527	55,335,503	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	676	676	0	0	18,580	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,200	13,200	0	0	350,594	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	249	249	17,092	0	28,413	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	0	0	84,086	0	442,267	194.01
194.02	07952	NON ALLOWABLE MEALS	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)	3,139,309	3,329,635	4,156,954		10,521,527	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.338159	14.146807	0.185703		0.187298	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			33,201		659,201	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001483		0.011735	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0184

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

Worksheet B-1

Date/Time Prepared:
9/25/2018 6:18 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	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: 14-0184

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

Worksheet B-1

Date/Time Prepared:
9/25/2018 6:18 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT	159,156					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	496	393,076				8.00
9.00	00900 HOUSEKEEPING	1,345	0	157,315			9.00
10.00	01000 DIETARY	3,665	0	3,665	126,035		10.00
11.00	01100 CAFETERIA	4,142	0	4,142	89,252	29,696	11.00
13.00	01300 NURSING ADMINISTRATION	5,710	0	5,710	0	1,633	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	2,331	0	2,331	0	610	14.00
15.00	01500 PHARMACY	2,120	0	2,120	0	1,230	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	3,430	0	3,430	0	698	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	36,992	155,257	36,992	25,089	5,383	30.00
31.00	03100 INTENSIVE CARE UNIT	12,244	41,045	12,244	3,691	1,458	31.00
43.00	04300 NURSERY	1,986	0	1,986	0	983	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	20,529	35,777	20,529	0	3,190	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	4,790	0	4,790	0	1,905	52.00
53.00	05300 ANESTHESIOLOGY	595	0	595	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	7,290	57,833	7,290	0	2,042	54.00
54.01	05401 ULTRASOUND	2,086	0	2,086	0	261	54.01
56.00	05600 RADIOISOTOPE	691	0	691	0	158	56.00
57.00	05700 CT SCAN	1,202	0	1,202	0	550	57.00
58.00	05800 MRI	1,277	0	1,277	0	118	58.00
60.00	06000 LABORATORY	4,738	0	4,738	0	2,691	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	252	0	252	0	95	62.00
65.00	06500 RESPIRATORY THERAPY	1,085	0	1,085	0	960	65.00
66.00	06600 PHYSICAL THERAPY	6,545	17,417	6,545	0	878	66.00
67.00	06700 OCCUPATIONAL THERAPY	165	0	165	0	155	67.00
68.00	06800 SPEECH PATHOLOGY	93	0	93	0	120	68.00
69.00	06900 ELECTROCARDIOLOGY	4,190	55,671	4,190	0	1,888	69.00
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	334	0	334	0	0	74.00
76.00	03020 ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610 SLEEP LAB	2,356	2,870	2,356	0	0	76.01
76.03	03951 WOUND CARE	2,814	39	2,814	0	323	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	9,538	27,167	9,538	1,110	2,228	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	145,031	393,076	143,190	119,142	29,557	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	676	0	676	0	0	190.00
191.00	19100 RESEARCH	0	0	0	0	0	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	13,200	0	13,200	6,893	0	192.00
193.00	19300 NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301 SENIOR CIRCLE	249	0	249	0	35	193.01
194.00	07950 OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953 MARKETING	0	0	0	0	104	194.01
194.02	07952 NON ALLOWABLE MEALS	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)	4,552,021	350,141	1,491,268	1,475,891	1,532,754	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	28.601002	0.890772	9.479503	11.710168	51.614830	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1,451,507	21,478	63,592	148,847	261,958	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	9.120027	0.054641	0.404234	1.180997	8.821323	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0184

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

Worksheet B-1

Date/Time Prepared:
9/25/2018 6:18 pm

Cost Center Description		NURSING ADMINISTRATION (NURSING WA GES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	
		13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION	14,440,609			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,396,427		14.00
15.00	01500	PHARMACY	0	37,079	2,540,491	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,717	0	16.00
					650,679,903	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,318,218	409,512	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,313,907	165,053	0	31.00
43.00	04300	NURSERY	679,191	39,750	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,208,393	2,300,467	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,235,149	9,873	0	52.00
53.00	05300	ANESTHESIOLOGY	0	170,246	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,373,508	51,809	0	54.00
54.01	05401	ULTRASOUND	197,168	2,364	0	54.01
56.00	05600	RADIOISOTOPE	139,365	3,759	0	56.00
57.00	05700	CT SCAN	347,155	38,661	0	57.00
58.00	05800	MRI	94,249	686	0	58.00
60.00	06000	LABORATORY	0	686,333	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	25,122	0	62.00
65.00	06500	RESPIRATORY THERAPY	524,993	72,101	0	65.00
66.00	06600	PHYSICAL THERAPY	0	14,504	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,204,558	371,540	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,262,952	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,305,328	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,540,491	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	76.00
76.01	03610	SLEEP LAB	0	16,074	0	76.01
76.03	03951	WOUND CARE	187,103	24,309	0	76.03
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,617,652	374,211	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,440,609	11,392,450	2,540,491	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	0	755	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	194.00
194.01	07953	MARKETING	0	3,222	0	194.01
194.02	07952	NON ALLOWABLE MEALS	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)	2,552,129	5,558,050	1,926,849	202.00
203.00		Unit cost multiplier (wkst. B, Part I)	0.176733	0.487701	0.758455	203.00
204.00		Cost to be allocated (per wkst. B, Part II)	249,915	145,755	108,793	204.00
205.00		Unit cost multiplier (wkst. B, Part II)	0.017306	0.012790	0.042824	205.00
206.00		NAHE adjustment amount to be allocated (per wkst. B-2)				206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0184

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

Worksheet B-1

Date/Time Prepared:
9/25/2018 6:18 pm

Cost Center Description		NURSING ADMINISTRATION (NURSING WA GES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)		
		13.00	14.00	15.00	16.00		
207.00	NAHE unit cost multiplier (wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet C
Part I
Date/Time Prepared:
9/25/2018 6:18 pm

			Title XVIII		Hospital		PPS
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	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	10,905,393		10,905,393	0	10,905,393
31.00	03100	INTENSIVE CARE UNIT	3,568,372		3,568,372	0	3,568,372
43.00	04300	NURSERY	1,223,114		1,223,114	0	1,223,114
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	9,507,212		9,507,212	0	9,507,212
51.00	05100	RECOVERY ROOM	0		0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,515,618		2,515,618	0	2,515,618
53.00	05300	ANESTHESIOLOGY	393,965		393,965	0	393,965
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,956,121		3,956,121	0	3,956,121
54.01	05401	ULTRASOUND	510,413		510,413	0	510,413
56.00	05600	RADIOISOTOPE	639,253		639,253	0	639,253
57.00	05700	CT SCAN	862,514		862,514	0	862,514
58.00	05800	MRI	278,336		278,336	0	278,336
60.00	06000	LABORATORY	4,499,091		4,499,091	0	4,499,091
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	585,800		585,800	0	585,800
65.00	06500	RESPIRATORY THERAPY	1,184,636	0	1,184,636	0	1,184,636
66.00	06600	PHYSICAL THERAPY	1,541,361	0	1,541,361	0	1,541,361
67.00	06700	OCCUPATIONAL THERAPY	196,188	0	196,188	0	196,188
68.00	06800	SPEECH PATHOLOGY	186,720	0	186,720	0	186,720
69.00	06900	ELECTROCARDIOLOGY	4,174,764		4,174,764	0	4,174,764
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,724,127		2,724,127	0	2,724,127
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,762,942		4,762,942	0	4,762,942
73.00	07300	DRUGS CHARGED TO PATIENTS	5,049,893		5,049,893	0	5,049,893
74.00	07400	RENAL DIALYSIS	308,817		308,817	0	308,817
76.00	03020	ACUPUNCTURE	0		0	0	0
76.01	03610	SLEEP LAB	204,595		204,595	0	204,595
76.03	03951	WOUND CARE	628,907		628,907	0	628,907
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	4,663,856		4,663,856	0	4,663,856
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,148,862		2,148,862		2,148,862
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0		0	0	0
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0
200.00		Subtotal (see instructions)	67,220,870	0	67,220,870	0	67,220,870
201.00		Less Observation Beds	2,148,862		2,148,862		2,148,862
202.00		Total (see instructions)	65,072,008	0	65,072,008	0	65,072,008

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet C
Part I
Date/Time Prepared:
9/25/2018 6:18 pm

			Title XVIII			Hospital	PPS
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,377,879		35,377,879		30.00
31.00	03100	INTENSIVE CARE UNIT	8,908,700		8,908,700		31.00
43.00	04300	NURSERY	3,113,056		3,113,056		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	44,031,595	60,819,870	104,851,465	0.090673	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,366,836	28,535	4,395,371	0.572333	52.00
53.00	05300	ANESTHESIOLOGY	10,418,506	11,484,770	21,903,276	0.017987	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,355,787	11,657,638	16,013,425	0.247050	54.00
54.01	05401	ULTRASOUND	1,509,544	4,091,878	5,601,422	0.091122	54.01
56.00	05600	RADIOISOTOPE	4,956,147	11,709,891	16,666,038	0.038357	56.00
57.00	05700	CT SCAN	10,587,347	30,717,676	41,305,023	0.020882	57.00
58.00	05800	MRI	1,500,921	6,651,147	8,152,068	0.034143	58.00
60.00	06000	LABORATORY	40,978,000	61,946,036	102,924,036	0.043713	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,569,249	1,884,166	3,453,415	0.169629	62.00
65.00	06500	RESPIRATORY THERAPY	13,446,214	2,840,312	16,286,526	0.072737	65.00
66.00	06600	PHYSICAL THERAPY	5,626,089	5,198,168	10,824,257	0.142399	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,352,800	1,264,392	2,617,192	0.074961	67.00
68.00	06800	SPEECH PATHOLOGY	865,977	455,638	1,321,615	0.141282	68.00
69.00	06900	ELECTROCARDIOLOGY	42,431,455	29,469,864	71,901,319	0.058062	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,024,067	4,942,195	14,966,262	0.182018	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	31,609,180	13,217,807	44,826,987	0.106252	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,234,924	19,159,444	44,394,368	0.113751	73.00
74.00	07400	RENAL DIALYSIS	1,452,342	143,131	1,595,473	0.193558	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	2,097,050	2,097,050	0.097563	76.01
76.03	03951	WOUND CARE	22,927	1,153,812	1,176,739	0.534449	76.03
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	13,897,223	43,607,141	57,504,364	0.081104	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,386,985	6,115,592	8,502,577	0.252731	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	96.00
200.00		Subtotal (see instructions)	320,023,750	330,656,153	650,679,903		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	320,023,750	330,656,153	650,679,903		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet C
Part I
Date/Time Prepared:
9/25/2018 6:18 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.090673			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.572333			52.00
53.00	05300 ANESTHESIOLOGY	0.017987			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.247050			54.00
54.01	05401 ULTRASOUND	0.091122			54.01
56.00	05600 RADIOISOTOPE	0.038357			56.00
57.00	05700 CT SCAN	0.020882			57.00
58.00	05800 MRI	0.034143			58.00
60.00	06000 LABORATORY	0.043713			60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.169629			62.00
65.00	06500 RESPIRATORY THERAPY	0.072737			65.00
66.00	06600 PHYSICAL THERAPY	0.142399			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.074961			67.00
68.00	06800 SPEECH PATHOLOGY	0.141282			68.00
69.00	06900 ELECTROCARDIOLOGY	0.058062			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.182018			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.106252			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.113751			73.00
74.00	07400 RENAL DIALYSIS	0.193558			74.00
76.00	03020 ACUPUNCTURE	0.000000			76.00
76.01	03610 SLEEP LAB	0.097563			76.01
76.03	03951 WOUND CARE	0.534449			76.03
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.081104			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.252731			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000			96.00
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: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet C
Part I
Date/Time Prepared:
9/25/2018 6:18 pm

Cost Center Description		Title XIX		Hospital		Cost	
		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	10,905,393		10,905,393	0	10,905,393	30.00
31.00	03100 INTENSIVE CARE UNIT	3,568,372		3,568,372	0	3,568,372	31.00
43.00	04300 NURSERY	1,223,114		1,223,114	0	1,223,114	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	9,507,212		9,507,212	0	9,507,212	50.00
51.00	05100 RECOVERY ROOM	0		0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2,515,618		2,515,618	0	2,515,618	52.00
53.00	05300 ANESTHESIOLOGY	393,965		393,965	0	393,965	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,956,121		3,956,121	0	3,956,121	54.00
54.01	05401 ULTRASOUND	510,413		510,413	0	510,413	54.01
56.00	05600 RADIOISOTOPE	639,253		639,253	0	639,253	56.00
57.00	05700 CT SCAN	862,514		862,514	0	862,514	57.00
58.00	05800 MRI	278,336		278,336	0	278,336	58.00
60.00	06000 LABORATORY	4,499,091		4,499,091	0	4,499,091	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	585,800		585,800	0	585,800	62.00
65.00	06500 RESPIRATORY THERAPY	1,184,636	0	1,184,636	0	1,184,636	65.00
66.00	06600 PHYSICAL THERAPY	1,541,361	0	1,541,361	0	1,541,361	66.00
67.00	06700 OCCUPATIONAL THERAPY	196,188	0	196,188	0	196,188	67.00
68.00	06800 SPEECH PATHOLOGY	186,720	0	186,720	0	186,720	68.00
69.00	06900 ELECTROCARDIOLOGY	4,174,764		4,174,764	0	4,174,764	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2,724,127		2,724,127	0	2,724,127	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	4,762,942		4,762,942	0	4,762,942	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	5,049,893		5,049,893	0	5,049,893	73.00
74.00	07400 RENAL DIALYSIS	308,817		308,817	0	308,817	74.00
76.00	03020 ACUPUNCTURE	0		0	0	0	76.00
76.01	03610 SLEEP LAB	204,595		204,595	0	204,595	76.01
76.03	03951 WOUND CARE	628,907		628,907	0	628,907	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	4,663,856		4,663,856	0	4,663,856	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2,148,862		2,148,862		2,148,862	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0		0	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
200.00	Subtotal (see instructions)	67,220,870	0	67,220,870	0	67,220,870	200.00
201.00	Less Observation Beds	2,148,862		2,148,862		2,148,862	201.00
202.00	Total (see instructions)	65,072,008	0	65,072,008	0	65,072,008	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet C
Part I
Date/Time Prepared:
9/25/2018 6:18 pm

Cost Center Description		Title XIX			Hospital	Cost	
		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	35,377,879		35,377,879			30.00
31.00	03100 INTENSIVE CARE UNIT	8,908,700		8,908,700			31.00
43.00	04300 NURSERY	3,113,056		3,113,056			43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	44,031,595	60,819,870	104,851,465	0.090673	0.000000	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	4,366,836	28,535	4,395,371	0.572333	0.000000	52.00
53.00	05300 ANESTHESIOLOGY	10,418,506	11,484,770	21,903,276	0.017987	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,355,787	11,657,638	16,013,425	0.247050	0.000000	54.00
54.01	05401 ULTRASOUND	1,509,544	4,091,878	5,601,422	0.091122	0.000000	54.01
56.00	05600 RADIOISOTOPE	4,956,147	11,709,891	16,666,038	0.038357	0.000000	56.00
57.00	05700 CT SCAN	10,587,347	30,717,676	41,305,023	0.020882	0.000000	57.00
58.00	05800 MRI	1,500,921	6,651,147	8,152,068	0.034143	0.000000	58.00
60.00	06000 LABORATORY	40,978,000	61,946,036	102,924,036	0.043713	0.000000	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1,569,249	1,884,166	3,453,415	0.169629	0.000000	62.00
65.00	06500 RESPIRATORY THERAPY	13,446,214	2,840,312	16,286,526	0.072737	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	5,626,089	5,198,168	10,824,257	0.142399	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,352,800	1,264,392	2,617,192	0.074961	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	865,977	455,638	1,321,615	0.141282	0.000000	68.00
69.00	06900 ELECTROCARDIOLOGY	42,431,455	29,469,864	71,901,319	0.058062	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10,024,067	4,942,195	14,966,262	0.182018	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	31,609,180	13,217,807	44,826,987	0.106252	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	25,234,924	19,159,444	44,394,368	0.113751	0.000000	73.00
74.00	07400 RENAL DIALYSIS	1,452,342	143,131	1,595,473	0.193558	0.000000	74.00
76.00	03020 ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610 SLEEP LAB	0	2,097,050	2,097,050	0.097563	0.000000	76.01
76.03	03951 WOUND CARE	22,927	1,153,812	1,176,739	0.534449	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	13,897,223	43,607,141	57,504,364	0.081104	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2,386,985	6,115,592	8,502,577	0.252731	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
200.00	Subtotal (see instructions)	320,023,750	330,656,153	650,679,903			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	320,023,750	330,656,153	650,679,903			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet C
Part I
Date/Time Prepared:
9/25/2018 6:18 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	05401 ULTRASOUND	0.000000			54.01
56.00	05600 RADIOISOTOPE	0.000000			56.00
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MRI	0.000000			58.00
60.00	06000 LABORATORY	0.000000			60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000			62.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400 RENAL DIALYSIS	0.000000			74.00
76.00	03020 ACUPUNCTURE	0.000000			76.00
76.01	03610 SLEEP LAB	0.000000			76.01
76.03	03951 WOUND CARE	0.000000			76.03
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000			96.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet D
Part I
Date/Time Prepared:
9/25/2018 6:18 pm

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	1,610,985	0	1,610,985	12,393	129.99	30.00	
31.00	INTENSIVE CARE UNIT	527,250		527,250	1,671	315.53	31.00	
43.00	NURSERY	105,217		105,217	1,468	71.67	43.00	
200.00	Total (lines 30 through 199)	2,243,452		2,243,452	15,532		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	4,820	626,552					30.00
31.00	INTENSIVE CARE UNIT	827	260,943					31.00
43.00	NURSERY	0	0					43.00
200.00	Total (lines 30 through 199)	5,647	887,495					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet D
Part II
Date/Time Prepared:
9/25/2018 6:18 pm

Cost Center Description		Title XVIII			Hospital		PPS
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	951,169	104,851,465	0.009072	18,533,434	168,135	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	237,739	4,395,371	0.054088	66,970	3,622	52.00
53.00	05300 ANESTHESIOLOGY	31,498	21,903,276	0.001438	3,706,760	5,330	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	352,852	16,013,425	0.022035	2,406,946	53,037	54.00
54.01	05401 ULTRASOUND	88,146	5,601,422	0.015736	830,103	13,063	54.01
56.00	05600 RADIOISOTOPE	38,737	16,666,038	0.002324	2,490,765	5,789	56.00
57.00	05700 CT SCAN	71,747	41,305,023	0.001737	5,766,680	10,017	57.00
58.00	05800 MRI	53,781	8,152,068	0.006597	883,883	5,831	58.00
60.00	06000 LABORATORY	268,414	102,924,036	0.002608	21,001,116	54,771	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	16,790	3,453,415	0.004862	909,756	4,423	62.00
65.00	06500 RESPIRATORY THERAPY	72,266	16,286,526	0.004437	7,524,066	33,384	65.00
66.00	06600 PHYSICAL THERAPY	266,315	10,824,257	0.024604	3,525,232	86,735	66.00
67.00	06700 OCCUPATIONAL THERAPY	9,971	2,617,192	0.003810	824,321	3,141	67.00
68.00	06800 SPEECH PATHOLOGY	6,687	1,321,615	0.005060	284,925	1,442	68.00
69.00	06900 ELECTROCARDIOLOGY	251,101	71,901,319	0.003492	20,922,763	73,062	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	55,971	14,966,262	0.003740	5,282,865	19,758	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	82,525	44,826,987	0.001841	15,227,974	28,035	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	148,684	44,394,368	0.003349	12,189,146	40,821	73.00
74.00	07400 RENAL DIALYSIS	15,612	1,595,473	0.009785	991,124	9,698	74.00
76.00	03020 ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03610 SLEEP LAB	89,016	2,097,050	0.042448	0	0	76.01
76.03	03951 WOUND CARE	115,609	1,176,739	0.098245	22,047	2,166	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	458,683	57,504,364	0.007976	7,677,685	61,237	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	317,438	8,502,577	0.037334	1,217,859	45,468	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00	Total (lines 50 through 199)	4,000,751	603,280,268		132,286,420	728,965	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet D
Part III
Date/Time Prepared:
9/25/2018 6:18 pm

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	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	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	12,393	0.00	4,820	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	1,671	0.00	827	31.00	
43.00	04300	NURSERY		0	1,468	0.00	0	43.00	
200.00		Total (lines 30 through 199)		0	15,532		5,647	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
43.00	04300	NURSERY	0						43.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet D
Part IV
Date/Time Prepared:
9/25/2018 6:18 pm

Cost Center Description		Title XVIII			Hospital	PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401 ULTRASOUND	0	0	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO 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
76.00	03020 ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610 SLEEP LAB	0	0	0	0	0	76.01
76.03	03951 WOUND CARE	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
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: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet D
Part IV
Date/Time Prepared:
9/25/2018 6:18 pm

Cost Center Description		Title XVIII			Hospital		PPS	
		All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	0	0	0	104,851,465	0.000000	50.00	
51.00	05100 RECOVERY ROOM	0	0	0	0	0.000000	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	4,395,371	0.000000	52.00	
53.00	05300 ANESTHESIOLOGY	0	0	0	21,903,276	0.000000	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	16,013,425	0.000000	54.00	
54.01	05401 ULTRASOUND	0	0	0	5,601,422	0.000000	54.01	
56.00	05600 RADIOISOTOPE	0	0	0	16,666,038	0.000000	56.00	
57.00	05700 CT SCAN	0	0	0	41,305,023	0.000000	57.00	
58.00	05800 MRI	0	0	0	8,152,068	0.000000	58.00	
60.00	06000 LABORATORY	0	0	0	102,924,036	0.000000	60.00	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	3,453,415	0.000000	62.00	
65.00	06500 RESPIRATORY THERAPY	0	0	0	16,286,526	0.000000	65.00	
66.00	06600 PHYSICAL THERAPY	0	0	0	10,824,257	0.000000	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	2,617,192	0.000000	67.00	
68.00	06800 SPEECH PATHOLOGY	0	0	0	1,321,615	0.000000	68.00	
69.00	06900 ELECTROCARDIOLOGY	0	0	0	71,901,319	0.000000	69.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	14,966,262	0.000000	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	44,826,987	0.000000	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	44,394,368	0.000000	73.00	
74.00	07400 RENAL DIALYSIS	0	0	0	1,595,473	0.000000	74.00	
76.00	03020 ACUPUNCTURE	0	0	0	0	0.000000	76.00	
76.01	03610 SLEEP LAB	0	0	0	2,097,050	0.000000	76.01	
76.03	03951 WOUND CARE	0	0	0	1,176,739	0.000000	76.03	
OUTPATIENT SERVICE COST CENTERS								
91.00	09100 EMERGENCY	0	0	0	57,504,364	0.000000	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	8,502,577	0.000000	92.00	
OTHER REIMBURSABLE COST CENTERS								
95.00	09500 AMBULANCE SERVICES						95.00	
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0.000000	96.00	
200.00	Total (lines 50 through 199)	0	0	0	603,280,268		200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet D
Part IV
Date/Time Prepared:
9/25/2018 6:18 pm

Cost Center Description			Title XVIII			Hospital		PPS	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	18,533,434	0	17,874,440	0	50.00	
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	66,970	0	545	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.000000	3,706,760	0	2,600,257	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,406,946	0	3,696,355	0	54.00	
54.01	05401	ULTRASOUND	0.000000	830,103	0	1,186,627	0	54.01	
56.00	05600	RADIOISOTOPE	0.000000	2,490,765	0	3,469,871	0	56.00	
57.00	05700	CT SCAN	0.000000	5,766,680	0	9,201,107	0	57.00	
58.00	05800	MRI	0.000000	883,883	0	2,183,496	0	58.00	
60.00	06000	LABORATORY	0.000000	21,001,116	0	8,953,699	0	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	909,756	0	1,525,018	0	62.00	
65.00	06500	RESPIRATORY THERAPY	0.000000	7,524,066	0	1,209,852	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.000000	3,525,232	0	241,510	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	824,321	0	45,739	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	284,925	0	5,665	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.000000	20,922,763	0	13,899,945	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	5,282,865	0	1,575,978	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	15,227,974	0	7,243,751	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	12,189,146	0	9,292,203	0	73.00	
74.00	07400	RENAL DIALYSIS	0.000000	991,124	0	90,895	0	74.00	
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00	
76.01	03610	SLEEP LAB	0.000000	0	0	663,516	0	76.01	
76.03	03951	WOUND CARE	0.000000	22,047	0	418,660	0	76.03	
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	0.000000	7,677,685	0	9,290,214	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,217,859	0	2,115,426	0	92.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES						95.00	
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00	
200.00	Total (lines 50 through 199)			132,286,420	0	96,784,769	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet D
Part V
Date/Time Prepared:
9/25/2018 6:18 pm

		Title XVIII		Hospital		PPS	
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	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	0.090673	17,874,440	0	0	1,620,729	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.572333	545	0	0	312	52.00
53.00	05300 ANESTHESIOLOGY	0.017987	2,600,257	0	0	46,771	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.247050	3,696,355	0	0	913,185	54.00
54.01	05401 ULTRASOUND	0.091122	1,186,627	0	0	108,128	54.01
56.00	05600 RADIOISOTOPE	0.038357	3,469,871	0	0	133,094	56.00
57.00	05700 CT SCAN	0.020882	9,201,107	0	0	192,138	57.00
58.00	05800 MRI	0.034143	2,183,496	0	0	74,551	58.00
60.00	06000 LABORATORY	0.043713	8,953,699	0	0	391,393	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.169629	1,525,018	0	0	258,687	62.00
65.00	06500 RESPIRATORY THERAPY	0.072737	1,209,852	0	0	88,001	65.00
66.00	06600 PHYSICAL THERAPY	0.142399	241,510	0	0	34,391	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.074961	45,739	0	0	3,429	67.00
68.00	06800 SPEECH PATHOLOGY	0.141282	5,665	0	0	800	68.00
69.00	06900 ELECTROCARDIOLOGY	0.058062	13,899,945	0	0	807,059	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.182018	1,575,978	0	0	286,856	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.106252	7,243,751	0	0	769,663	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.113751	9,292,203	28,155	0	1,056,997	73.00
74.00	07400 RENAL DIALYSIS	0.193558	90,895	0	0	17,593	74.00
76.00	03020 ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610 SLEEP LAB	0.097563	663,516	0	0	64,735	76.01
76.03	03951 WOUND CARE	0.534449	418,660	0	0	223,752	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0.081104	9,290,214	0	0	753,474	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.252731	2,115,426	0	0	534,634	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0.000000	0	0	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00	Subtotal (see instructions)		96,784,769	28,155	0	8,380,372	200.00
201.00	Less PBP Clinic Lab. Services-Program			0	0		201.00
202.00	Only Charges						
202.00	Net Charges (line 200 - line 201)		96,784,769	28,155	0	8,380,372	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet D
Part V
Date/Time Prepared:
9/25/2018 6:18 pm

		Title XVIII		Hospital		9/23/2016 6:16 pm	
Cost Center Description		Costs				PPS	
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
		6.00	7.00				
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0				50.00
51.00	05100 RECOVERY ROOM	0	0				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53.00	05300 ANESTHESIOLOGY	0	0				53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0				54.00
54.01	05401 ULTRASOUND	0	0				54.01
56.00	05600 RADIOISOTOPE	0	0				56.00
57.00	05700 CT SCAN	0	0				57.00
58.00	05800 MRI	0	0				58.00
60.00	06000 LABORATORY	0	0				60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				62.00
65.00	06500 RESPIRATORY THERAPY	0	0				65.00
66.00	06600 PHYSICAL THERAPY	0	0				66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0				67.00
68.00	06800 SPEECH PATHOLOGY	0	0				68.00
69.00	06900 ELECTROCARDIOLOGY	0	0				69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,203	0				73.00
74.00	07400 RENAL DIALYSIS	0	0				74.00
76.00	03020 ACUPUNCTURE	0	0				76.00
76.01	03610 SLEEP LAB	0	0				76.01
76.03	03951 WOUND CARE	0	0				76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0	0				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0					95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0				96.00
200.00	Subtotal (see instructions)	3,203	0				200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0					201.00
202.00	Net Charges (line 200 - line 201)	3,203	0				202.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0184

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

Worksheet D-1

Date/Time Prepared:
9/25/2018 6:18 pm

		Title XVIII	Hospital	PPS	
Cost Center Description					
		1.00			
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		12,396		1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		12,393		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)		9,951		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)		3		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)		4,820		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)		10,905,393		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)		10,905,393		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)		10,905,393		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)		879.96		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,241,407		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)		4,241,407		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0184

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

Worksheet D-1

Date/Time Prepared:

9/25/2018 6:18 pm

Cost Center Description		Title XVIII			Hospital		PPS
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,568,372	1,671	2,135.47	827	1,766,034	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description						
						1.00	
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					11,240,585	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					17,248,026	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)					887,495	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					728,965	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,616,460	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					15,631,566	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					2,442	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					879.96	88.00
89.00	observation bed cost (line 87 x line 88) (see instructions)					2,148,862	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0184

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

Worksheet D-1

Date/Time Prepared:
9/25/2018 6:18 pm

Title XVIII		Hospital		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
	1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
90.00 Capital-related cost	1,610,985	10,905,393	0.147724	2,148,862	317,438
91.00 Nursing School cost	0	10,905,393	0.000000	2,148,862	0
92.00 Allied health cost	0	10,905,393	0.000000	2,148,862	0
93.00 All other Medical Education	0	10,905,393	0.000000	2,148,862	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0184

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

Worksheet D-3

Date/Time Prepared:
9/25/2018 6:18 pm

Cost Center Description		Title XVIII	Hospital	PPS
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			
31.00	03100 INTENSIVE CARE UNIT		18,420,356	
43.00	04300 NURSERY		4,402,717	
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.090673	18,533,434	1,680,482
51.00	05100 RECOVERY ROOM	0.000000	0	0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.572333	66,970	38,329
53.00	05300 ANESTHESIOLOGY	0.017987	3,706,760	66,673
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.247050	2,406,946	594,636
54.01	05401 ULTRASOUND	0.091122	830,103	75,641
56.00	05600 RADIOISOTOPE	0.038357	2,490,765	95,538
57.00	05700 CT SCAN	0.020882	5,766,680	120,420
58.00	05800 MRI	0.034143	883,883	30,178
60.00	06000 LABORATORY	0.043713	21,001,116	918,022
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.169629	909,756	154,321
65.00	06500 RESPIRATORY THERAPY	0.072737	7,524,066	547,278
66.00	06600 PHYSICAL THERAPY	0.142399	3,525,232	501,990
67.00	06700 OCCUPATIONAL THERAPY	0.074961	824,321	61,792
68.00	06800 SPEECH PATHOLOGY	0.141282	284,925	40,255
69.00	06900 ELECTROCARDIOLOGY	0.058062	20,922,763	1,214,817
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.182018	5,282,865	961,577
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.106252	15,227,974	1,618,003
73.00	07300 DRUGS CHARGED TO PATIENTS	0.113751	12,189,146	1,386,528
74.00	07400 RENAL DIALYSIS	0.193558	991,124	191,840
76.00	03020 ACUPUNCTURE	0.000000	0	0
76.01	03610 SLEEP LAB	0.097563	0	0
76.03	03951 WOUND CARE	0.534449	22,047	11,783
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0.081104	7,677,685	622,691
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.252731	1,217,859	307,791
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES			
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0
200.00	Total (sum of lines 50 through 94 and 96 through 98)		132,286,420	11,240,585
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0
202.00	Net charges (line 200 minus line 201)		132,286,420	

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet E
Part A
Date/Time Prepared:
9/25/2018 6:18 pm

Title XVIII		Hospital	PPS	
			1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	5,079,071	1.01	
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	8,918,478	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)	203,562	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)	91.30	4.00	
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00	
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00	
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00	
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01	
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00	
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01	
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02	
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)	0.00	9.00	
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00	
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00	
12.00	Current year allowable FTE (see instructions)	0.00	12.00	
13.00	Total allowable FTE count for the prior year.	0.00	13.00	
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00	
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00	
16.00	Adjustment for residents in initial years of the program	0.00	16.00	
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00	
18.00	Adjusted rolling average FTE count	0.00	18.00	
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00	
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00	
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00	
22.00	IME payment adjustment (see instructions)	0	22.00	
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01	
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00	
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00	
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00	
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00	
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00	
28.00	IME add-on adjustment amount (see instructions)	0	28.00	
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01	
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00	
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01	
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	5.97	30.00	
31.00	Percentage of Medicaid patient days (see instructions)	29.23	31.00	
32.00	Sum of lines 30 and 31	35.20	32.00	
33.00	Allowable disproportionate share percentage (see instructions)	12.00	33.00	
34.00	Disproportionate share adjustment (see instructions)	419,926	34.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet E
Part A
Date/Time Prepared:
9/25/2018 6:18 pm

		Title XVIII	Hospital	PPS	9/25/2018 6:18 pm
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)		0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		883,720	700,249	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		370,436	406,720	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		777,156		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		15,398,193		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		0		48.00
			Amount		
			1.00		
49.00	Total payment for inpatient operating costs (see instructions)			15,398,193	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			1,169,880	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			0	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			16,568,073	59.00
60.00	Primary payer payments			4,798	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			16,563,275	61.00
62.00	Deductibles billed to program beneficiaries			1,525,392	62.00
63.00	Coinsurance billed to program beneficiaries			6,359	63.00
64.00	Allowable bad debts (see instructions)			441,614	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			287,049	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			404,731	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			15,318,573	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			5,725	70.93
70.94	HRR adjustment amount (see instructions)			-354,917	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet E
Part A
Date/Time Prepared:
9/25/2018 6:18 pm

		Title XVIII	Hospital	PPS	
		FFY (yyyy)		Amount	
		0		1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0		0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			14,969,381	71.00
71.01	Sequestration adjustment (see instructions)			299,388	71.01
71.02	Demonstration payment adjustment amount after sequestration			0	71.02
72.00	Interim payments			14,736,602	72.00
73.00	Tentative settlement (for contractor use only)			0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)			-66,609	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			2,676,672	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	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	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	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

		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	5,079,071	0	5,079,071		5,079,071
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	8,918,478	0		8,918,478	8,918,478
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	203,562	0	0	203,562	203,562
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	
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	
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	0.1200	0.1200	0.1200	0.1200	
11.00	Disproportionate share adjustment (see instructions)	34.00	419,926	0	152,372	267,554	419,926
11.01	Uncompensated care payments	36.00	777,156	0	370,436	406,720	777,156
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	15,398,193	0	5,601,879	9,796,314	15,398,193
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	15,398,193	0	5,601,879	9,796,314	15,398,193
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,169,880	0	490,388	679,492	1,169,880
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0
17.01	Net organ acquisition 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: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet E
Part A Exhibit 4
Date/Time Prepared:
9/25/2018 6:18 pm

		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	6,092,267	10,475,806	16,568,073
		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	1,121,669	0	470,179	651,490	1,121,669
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	48,211	0	20,209	28,002	48,211
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	0.0000	0.0000	0.0000	0.0000	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0
26.00	Total prospective capital payments (see instructions)	12.00	1,169,880	0	490,388	679,492	1,169,880
		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				0.000000	0.000000	
28.00	Low volume adjustment (transfer amount to wkst. E, Pt. A, line)	70.96			0		0
29.00	Low volume adjustment (transfer amount to wkst. E, Pt. A, line)	70.97				0	0
100.00	Transfer low volume adjustments to wkst. E, Pt. A.		Y				

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet E
Part B
Date/Time Prepared:
9/25/2018 6:18 pm

Title XVIII

Hospital

PPS

1.00

PART B - MEDICAL AND OTHER HEALTH SERVICES

1.00	Medical and other services (see instructions)		
2.00	Medical and other services reimbursed under OPPS (see instructions)	3,203	1.00
3.00	OPPS payments	8,380,372	2.00
4.00	Outlier payment (see instructions)	7,221,665	3.00
4.01	Outlier reconciliation amount (see instructions)	134,123	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0	4.01
6.00	Line 2 times line 5	0.000	5.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0	6.00
8.00	Transitional corridor payment (see instructions)	0.00	7.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	8.00
10.00	Organ acquisitions	0	9.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	10.00
	COMPUTATION OF LESSER OF COST OR CHARGES	3,203	11.00
	Reasonable charges		
12.00	Ancillary service charges	28,155	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)	28,155	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)	28,155	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	24,952	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)	3,203	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)	7,355,788	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	40,702	25.00
26.00	Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)	1,333,431	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)	5,984,858	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)	5,984,858	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	5,984,858	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)	279,674	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	181,788	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	240,536	36.00
37.00	Subtotal (see instructions)	6,166,646	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	6,166,646	40.00
40.01	Sequestration adjustment (see instructions)	123,333	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	6,061,812	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-18,499	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: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet E-1
Part I
Date/Time Prepared:
9/25/2018 6:18 pm

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		14,736,602		6,061,812	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		14,736,602		6,061,812	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)		0		0	6.00
6.01	SETTLEMENT TO PROVIDER		66,609		18,499	6.01
6.02	SETTLEMENT TO PROGRAM		14,669,993		6,043,313	6.02
7.00	Total Medicare program liability (see instructions)					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: 14-0184
 Component CCN: 14-U184

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

 Worksheet E-1
 Part I
 Date/Time Prepared:
 9/25/2018 6:18 pm

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet E-1
Part II
Date/Time Prepared:
9/25/2018 6:18 pm

Title XVIII

Hospital

PPS

1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS**HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION**

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-0184

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

Worksheet E-2

Date/Time Prepared:
9/25/2018 6:18 pm

Component CCN: 14-U184

Title XVIII

Swing Beds - SNF

PPS

Part A

Part B

1.00

2.00

COMPUTATION OF NET COST OF COVERED SERVICES

1.00	Inpatient routine services - swing bed-SNF (see instructions)	0	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)			3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days			
6.00	Interns and residents not in approved teaching program (see instructions)	0	0	5.00
7.00	Utilization review - physician compensation - SNF optional method only	0	0	6.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0	0	7.00
9.00	Primary payer payments (see instructions)	0	0	8.00
10.00	Subtotal (line 8 minus line 9)	0	0	9.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	10.00
12.00	Subtotal (line 10 minus line 11)	0	0	11.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	12.00
14.00	80% of Part B costs (line 12 x 80%)	0	0	13.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	0	0	14.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	15.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.00
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0	0	16.50
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.55
17.00	Allowable bad debts (see instructions)	0	0	16.99
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.00
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	17.01
19.00	Total (see instructions)	0	0	18.00
19.01	Sequestration adjustment (see instructions)	0	0	19.00
19.02	Demonstration payment adjustment amount after sequestration	0	0	19.01
20.00	Interim payments	0	0	19.02
21.00	Tentative settlement (for contractor use only)	0	0	20.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0	0	21.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	22.00
		0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparison of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

	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	-833,617	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	29,944,045	0	0	0	4.00
5.00 Other receivable	0	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-2,739,507	0	0	0	6.00
7.00 Inventory	3,696,606	0	0	0	7.00
8.00 Prepaid expenses	1,334,000	0	0	0	8.00
9.00 Other current assets	344,839	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)	31,746,366	0	0	0	11.00
FIXED ASSETS					
12.00 Land	1,393,860	0	0	0	12.00
13.00 Land improvements	561,093	0	0	0	13.00
14.00 Accumulated depreciation	-425,114	0	0	0	14.00
15.00 Buildings	47,007,264	0	0	0	15.00
16.00 Accumulated depreciation	-13,933,258	0	0	0	16.00
17.00 Leasehold improvements	6,588,349	0	0	0	17.00
18.00 Accumulated depreciation	-2,902,733	0	0	0	18.00
19.00 Fixed equipment	2,468,659	0	0	0	19.00
20.00 Accumulated depreciation	-1,846,542	0	0	0	20.00
21.00 Automobiles and trucks	2,994	0	0	0	21.00
22.00 Accumulated depreciation	-2,994	0	0	0	22.00
23.00 Major movable equipment	19,965,200	0	0	0	23.00
24.00 Accumulated depreciation	-16,089,089	0	0	0	24.00
25.00 Minor equipment depreciable	6,204,681	0	0	0	25.00
26.00 Accumulated depreciation	-5,403,922	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)	43,588,448	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	0	0	0	0	31.00
32.00 Deposits on leases	0	0	0	0	32.00
33.00 Due from owners/officers	0	0	0	0	33.00
34.00 Other assets	2,852,904	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	2,852,904	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	78,187,718	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	6,739,180	0	0	0	37.00
38.00 Salaries, wages, and fees payable	1,528,327	0	0	0	38.00
39.00 Payroll taxes payable	243,764	0	0	0	39.00
40.00 Notes and loans payable (short term)	27,500	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	-63,205,641	0	0	0	43.00
44.00 Other current liabilities	1,660,252	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	-53,006,618	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	33,332	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	0	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	33,332	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	-52,973,286	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	131,161,004	0	0	0	52.00
53.00 Specific purpose fund	0	0	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	131,161,004	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	78,187,718	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0184

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

Worksheet G-1

Date/Time Prepared:
9/25/2018 6:18 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period						1.00
2.00	Net income (loss) (from wkst. G-3, line 29)		97,295,637		0		2.00
3.00	Total (sum of line 1 and line 2)		33,865,368				3.00
4.00	ROUNDING		131,161,005		0		4.00
5.00		-1		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)		-1	0		0	10.00
11.00	Subtotal (line 3 plus line 10)		131,161,004		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		131,161,004		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	ROUNDING						4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0184

Period:
From 05/01/2017
To 04/30/2018Worksheet G-2
Parts I & II
Date/Time Prepared:
9/25/2018 6:18 pm

Cost Center Description		Inpatient 1.00	Outpatient 2.00	Total 3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	38,490,935		38,490,935	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	38,490,935		38,490,935	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	8,908,700		8,908,700	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	8,908,700		8,908,700	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	47,399,635		47,399,635	17.00
18.00	Ancillary services	256,336,907	280,936,420	537,273,327	18.00
19.00	Outpatient services	16,284,208	49,722,733	66,006,941	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	OTHER (SPECIFY)				27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	320,020,750	330,659,153	650,679,903	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		81,399,746		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	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)		81,399,746		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0184

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

Worksheet G-3

Date/Time Prepared:
9/25/2018 6:18 pm

1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	1.00	
2.00	Less contractual allowances and discounts on patients' accounts	650,679,903	1.00
3.00	Net patient revenues (line 1 minus line 2)	535,720,061	2.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	114,959,842	3.00
5.00	Net income from service to patients (line 3 minus line 4)	81,399,746	4.00
	OTHER INCOME	33,560,096	5.00
6.00	Contributions, donations, bequests, etc		
7.00	Income from investments	0	6.00
8.00	Revenues from telephone and other miscellaneous communication services	0	7.00
9.00	Revenue from television and radio service	0	8.00
10.00	Purchase discounts	0	9.00
11.00	Rebates and refunds of expenses	0	10.00
12.00	Parking lot receipts	0	11.00
13.00	Revenue from laundry and linen service	0	12.00
14.00	Revenue from meals sold to employees and guests	0	13.00
15.00	Revenue from rental of living quarters	0	14.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	15.00
17.00	Revenue from sale of drugs to other than patients	0	16.00
18.00	Revenue from sale of medical records and abstracts	0	17.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	18.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	19.00
21.00	Rental of vending machines	0	20.00
22.00	Rental of hospital space	0	21.00
23.00	Governmental appropriations	0	22.00
24.00	OTHER (SPECIFY)	0	23.00
25.00	Total other income (sum of lines 6-24)	305,272	24.00
26.00	Total (line 5 plus line 25)	305,272	25.00
27.00	OTHER EXPENSES (SPECIFY)	33,865,368	26.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	27.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	0	28.00
		33,865,368	29.00

Health Financial Systems		HEARTLAND REGIONAL MEDICAL CENTER		In Lieu of Form CMS-2552-10	
CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0184	Period: From 05/01/2017 To 04/30/2018	Worksheet L Parts I-III Date/Time Prepared: 9/25/2018 6:18 pm	
		Title XVIII	Hospital	PPS	
				1.00	
PART I - FULLY PROSPECTIVE METHOD					
CAPITAL FEDERAL AMOUNT				1,121,669	1.00
1.00	Capital DRG other than outlier			0	1.01
1.01	Model 4 BPCI Capital DRG other than outlier			48,211	2.00
2.00	Capital DRG outlier payments			0	2.01
2.01	Model 4 BPCI Capital DRG outlier payments			33.46	3.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)			0.00	4.00
4.00	Number of interns & residents (see instructions)			0.00	5.00
5.00	Indirect medical education percentage (see instructions)			0	6.00
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)			0.00	7.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)			0.00	8.00
8.00	Percentage of Medicaid patient days to total days (see instructions)			0.00	9.00
9.00	Sum of lines 7 and 8			0.00	10.00
10.00	Allowable disproportionate share percentage (see instructions)			0	11.00
11.00	Disproportionate share adjustment (see instructions)			1,169,880	12.00
12.00	Total prospective capital payments (see instructions)				
				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