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: 14-0077	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/30/2019 11:00 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/30/2019 Time: 11:00 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] 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. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] 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 TOUCHETTE REGIONAL HOSPITAL (14-0077) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[X] 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) THOMAS CHAUNDY
Officer or Administrator of Provider(s)

CFO
Title

(Dated when report is electronically signed.)
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	28,055	33,295	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	28,055	33,295	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: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2019 11:00 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 5900 BOND STREET	PO Box:			1.00
2.00	City: CENTREVILLE	State: IL	Zip Code: 62207	County: ST. CLAIR	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	TOUCHETTE REGIONAL HOSPITAL	140077	41180	1	07/01/1966	N	P	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	SOUTHERN ILLINOIS HOME CARE	147315	41180		01/01/1996	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2018	12/31/2018	20.00
21.00	Type of Control (see instructions)	2		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N		23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	2,544	707	90	0	1,909	34	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2019 11:00 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N	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.	N			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.	N			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2019 11:00 am

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2019 11:00 am

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0077	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/30/2019 11:00 am

		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	N	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.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2019 11:00 am

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	1,647,713	0	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		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0077	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/30/2019 11:00 am

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: SOUTHERN ILLINOIS HEALTHCARE	Contractor's Name: NGS	Contractor's Number: 06101	141.00
142.00	Street: 2041 GOOSE LAKE ROAD	PO Box:		142.00
143.00	City: SAUGET	State:	Zip Code: 62206	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2017	09/30/2018	170.00

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 5/30/2019 11:00 am

			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.	Y	A	04/30/2019	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	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	05/02/2019	Y	05/02/2019
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 5/30/2019 11:00 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?			36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN	WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4446	KEVIN.WELLEN@CLACONNECT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0077	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/30/2019 11:00 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I Date/Time Prepared: 5/30/2019 11:00 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	122	44,530	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)		122	44,530	0.00	0	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	43.00				0	13.00
14.00	Total (see instructions)		122	44,530	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		122				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: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2019 11:00 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,069	2,653	9,777			1.00
2.00	HMO and other (see instructions)	0	2,569				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,069	2,653	9,777			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		32	65			13.00
14.00	Total (see instructions)	2,069	2,685	9,842	0.00	418.71	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	1,329	0	10,924	0.00	14.19	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	432.90	27.00
28.00	Observation Bed Days		0	698			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	30	34			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I Date/Time Prepared: 5/30/2019 11:00 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		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	420	1,539	2,533	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	420	1,539	2,533	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part II Date/Time Prepared: 5/30/2019 11:00 am

		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	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	25,160,224	0	25,160,224	900,433.13	27.94	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		359,614	0	359,614	4,283.44	83.95	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)		2,359,184	0	2,359,184	75,588.62	31.21	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		4,515,362	0	4,515,362	36,169.10	124.84	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		42,000	0	42,000	324.00	129.63	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		6,251,566	0	6,251,566			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		610,826	0	610,826			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		48,336	0	48,336			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	461,801	0	461,801	11,510.15	40.12	26.00
27.00	Administrative & General	5.00	4,838,764	0	4,838,764	157,458.30	30.73	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part II Date/Time Prepared: 5/30/2019 11:00 am

		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.)		223,009	0	223,009	1,496.86	148.98	28.00
29.00	Maintenance & Repairs	6.00	593,302	0	593,302	23,522.89	25.22	29.00
30.00	Operation of Plant	7.00	1,125,274	0	1,125,274	61,711.72	18.23	30.00
31.00	Laundry & Linen Service	8.00	24,143	0	24,143	2,132.58	11.32	31.00
32.00	Housekeeping	9.00	550,769	0	550,769	46,258.89	11.91	32.00
33.00	Housekeeping under contract (see instructions)		62,500	0	62,500	2,080.00	30.05	33.00
34.00	Dietary	10.00	439,286	-327,565	111,721	8,319.21	13.43	34.00
35.00	Dietary under contract (see instructions)		200,176	0	200,176	6,108.00	32.77	35.00
36.00	Cafeteria	11.00	0	327,565	327,565	24,391.75	13.43	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	525,107	0	525,107	14,356.16	36.58	38.00
39.00	Central Services and Supply	14.00	143,202	0	143,202	7,831.96	18.28	39.00
40.00	Pharmacy	15.00	755,480	-755,480	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	701,432	0	701,432	34,617.18	20.26	41.00
42.00	Social Service	17.00	317,487	0	317,487	11,917.35	26.64	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part III Date/Time Prepared: 5/30/2019 11:00 am

		Worksheet A Line Number	Amount Reported	Reclassification 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)		25,286,295	0	25,286,295	905,834.55	27.91	1.00
2.00	Excluded area salaries (see instructions)		2,359,184	0	2,359,184	75,588.62	31.21	2.00
3.00	Subtotal salaries (line 1 minus line 2)		22,927,111	0	22,927,111	830,245.93	27.61	3.00
4.00	Subtotal other wages & related costs (see inst.)		4,557,362	0	4,557,362	36,493.10	124.88	4.00
5.00	Subtotal wage-related costs (see inst.)		6,251,566	0	6,251,566	0.00	27.27	5.00
6.00	Total (sum of lines 3 thru 5)		33,736,039	0	33,736,039	866,739.03	38.92	6.00
7.00	Total overhead cost (see instructions)		10,961,732	-755,480	10,206,252	413,713.00	24.67	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part IV Date/Time Prepared: 5/30/2019 11:00 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	636,775	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	3,335,617	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	59,667	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	98,225	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	791,402	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	1,857,734	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	62,925	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	68,384	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	6,910,729	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part V Date/Time Prepared: 5/30/2019 11:00 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	4,515,362	6,910,729	1.00
2.00	Hospital	4,515,362	6,910,729	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	0	0	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

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 14-0077 | Component CCN: 14-7315 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-4 | Date/Time Prepared: 5/30/2019 11:00 am

Home Health Agency I | PPS

						1.00	
0.00	County				ST. CLAIR		0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	67.00	255.00	277.00	599.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			3.19	0.00	3.19	5.00
6.00	Direct Nursing Service			5.29	0.00	5.29	6.00
7.00	Nursing Supervisor			2.00	0.00	2.00	7.00
8.00	Physical Therapy Service			2.50	0.00	2.50	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			1.11	0.00	1.11	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.10	0.00	0.10	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			41180			20.00
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	467	0	29	4	500	21.00
22.00	Skilled Nursing Visit Charges	67,248	0	4,176	576	72,000	22.00
23.00	Physical Therapy Visits	514	15	6	4	539	23.00
24.00	Physical Therapy Visit Charges	74,016	2,160	864	576	77,616	24.00
25.00	Occupational Therapy Visits	232	13	0	0	245	25.00
26.00	Occupational Therapy Visit Charges	33,408	1,872	0	0	35,280	26.00
27.00	Speech Pathology Visits	14	17	0	2	33	27.00
28.00	Speech Pathology Visit Charges	2,016	2,448	0	288	4,752	28.00
29.00	Medical Social Service Visits	11	1	0	0	12	29.00
30.00	Medical Social Service Visit Charges	2,112	192	0	0	2,304	30.00
31.00	Home Health Aide Visits	0	0	0	0	0	31.00
32.00	Home Health Aide Visit Charges	0	0	0	0	0	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	1,238	46	35	10	1,329	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	178,800	6,672	5,040	1,440	191,952	35.00
36.00	Total Number of Episodes (standard/non outlier)	65		17	1	83	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	158	0	0	0	158	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-10 | Date/Time Prepared: 5/30/2019 11:00 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.760903	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	11,449,813	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	28,228,536	5.00
6.00	Medicaid charges	37,986,408	6.00
7.00	Medicaid cost (line 1 times line 6)	28,903,972	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)	0	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)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	3,060,130	499,362	3,559,492	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,328,462	499,362	2,827,824	21.00
22.00	Payments received from patients for amounts previously written off as charity care	1,062	2,764	3,826	22.00
23.00	Cost of charity care (line 21 minus line 22)	2,327,400	496,598	2,823,998	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,779,419	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	391,518	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	602,335	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,177,084	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,867,367	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	4,691,365	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,691,365	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/30/2019 11:00 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (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		1,167,364	1,167,364	162,012	1,329,376	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		519,795	519,795	66,343	586,138	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	461,801	5,300,284	5,762,085	-38,045	5,724,040	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,838,764	8,415,757	13,254,521	292,210	13,546,731	5.00
6.00	00600	MAINTENANCE & REPAIRS	593,302	407,410	1,000,712	0	1,000,712	6.00
7.00	00700	OPERATION OF PLANT	1,125,274	697,110	1,822,384	0	1,822,384	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	24,143	105,231	129,374	0	129,374	8.00
9.00	00900	HOUSEKEEPING	550,769	384,739	935,508	0	935,508	9.00
10.00	01000	DIETARY	439,286	606,344	1,045,630	-779,701	265,929	10.00
11.00	01100	CAFETERIA	0	0	0	779,701	779,701	11.00
13.00	01300	NURSING ADMINISTRATION	525,107	61,705	586,812	0	586,812	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	143,202	15,921	159,123	0	159,123	14.00
15.00	01500	PHARMACY	755,480	112,265	867,745	-755,480	112,265	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	701,432	155,281	856,713	0	856,713	16.00
17.00	01700	SOCIAL SERVICE	317,487	30,642	348,129	0	348,129	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,945,858	1,668,997	6,614,855	874,789	7,489,644	30.00
43.00	04300	NURSERY	330,910	34,537	365,447	0	365,447	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	900,706	302,066	1,202,772	0	1,202,772	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	666,530	793,741	1,460,271	-850,751	609,520	52.00
53.00	05300	ANESTHESIOLOGY	0	937,309	937,309	0	937,309	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,257,792	654,247	1,912,039	0	1,912,039	54.00
60.00	06000	LABORATORY	615,132	2,362,885	2,978,017	0	2,978,017	60.00
65.00	06500	RESPIRATORY THERAPY	726,644	413,207	1,139,851	0	1,139,851	65.00
66.00	06600	PHYSICAL THERAPY	0	427,432	427,432	0	427,432	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	202,304	202,304	0	202,304	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	223,682	223,682	0	223,682	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	392,908	392,908	755,480	1,148,388	73.00
74.00	07400	RENAL DIALYSIS	0	23,905	23,905	0	23,905	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	660,533	196,305	856,838	0	856,838	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,220,888	3,570,070	5,790,958	0	5,790,958	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,151,929	213,469	1,365,398	0	1,365,398	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		520,565	520,565	-520,565	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,952,969	30,917,477	54,870,446	-14,007	54,856,439	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,626	462	2,088	0	2,088	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	765,353	2,626,494	3,391,847	14,007	3,405,854	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	190,922	46,623	237,545	0	237,545	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	249,354	-103,575	145,779	0	145,779	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	25,160,224	33,487,481	58,647,705	0	58,647,705	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/30/2019 11:00 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-683	1,328,693		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-4,879	581,259		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,724,040		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,028,381	10,518,350		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	1,000,712		6.00
7.00	00700	OPERATION OF PLANT	0	1,822,384		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	129,374		8.00
9.00	00900	HOUSEKEEPING	0	935,508		9.00
10.00	01000	DIETARY	0	265,929		10.00
11.00	01100	CAFETERIA	-254,295	525,406		11.00
13.00	01300	NURSING ADMINISTRATION	-1,104	585,708		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	159,123		14.00
15.00	01500	PHARMACY	0	112,265		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-42,702	814,011		16.00
17.00	01700	SOCIAL SERVICE	0	348,129		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,252,887	6,236,757		30.00
43.00	04300	NURSERY	0	365,447		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,202,772		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-251,800	357,720		52.00
53.00	05300	ANESTHESIOLOGY	-927,641	9,668		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,912,039		54.00
60.00	06000	LABORATORY	0	2,978,017		60.00
65.00	06500	RESPIRATORY THERAPY	-87,573	1,052,278		65.00
66.00	06600	PHYSICAL THERAPY	-200	427,232		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	202,304		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	223,682		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,148,388		73.00
74.00	07400	RENAL DIALYSIS	0	23,905		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	-64,048	792,790		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-3,071,096	2,719,862		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	-1,441	1,363,957		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-8,988,730	45,867,709		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,088		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,405,854		192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	237,545		194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	0	145,779		194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-8,988,730	49,658,975		200.00

RECLASSIFICATIONS | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/30/2019 11:00 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA COSTS				
1.00	CAFETERIA	11.00	327,565	452,136	1.00
	0		327,565	452,136	
	B - ER & HOSPITALIST PHYSICIAN BENEFITS				
1.00	ADULTS & PEDIATRICS	30.00	0	24,038	1.00
	0		0	24,038	
	C - CLINIC PHYSICIAN BENEFITS				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	14,007	1.00
	0		0	14,007	
	D - INTEREST EXPENSE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	14,775	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	471,188	2.00
3.00	CAP REL COSTS-BLDG & FIXT	1.00	0	34,602	3.00
	0		0	520,565	
	E - PROPERTY INSURANCE				
1.00	OTHER CAP REL COSTS	3.00	0	178,978	1.00
	0		0	178,978	
	F - LABOR & DELIVERY				
1.00	ADULTS & PEDIATRICS	30.00	469,230	381,521	1.00
	0		469,230	381,521	
	G - PHARMACY SALARIES				
1.00	DRUGS CHARGED TO PATIENTS	73.00	755,480	0	1.00
	0		755,480	0	
500.00	Grand Total: Increases		1,552,275	1,571,245	500.00

RECLASSIFICATIONS | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/30/2019 11:00 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA COSTS						
1.00	DIETARY	10.00	327,565	452,136	0		1.00
	0		327,565	452,136			
	B - ER & HOSPITALIST PHYSICIAN BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	24,038	0		1.00
	0		0	24,038			
	C - CLINIC PHYSICIAN BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	14,007	0		1.00
	0		0	14,007			
	D - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	520,565	11		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	11		3.00
	0		0	520,565			
	E - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	178,978	0		1.00
	0		0	178,978			
	F - LABOR & DELIVERY						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	469,230	381,521	0		1.00
	0		469,230	381,521			
	G - PHARMACY SALARIES						
1.00	PHARMACY	15.00	755,480	0	0		1.00
	0		755,480	0			
500.00	Grand Total: Decreases		1,552,275	1,571,245			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part I | Date/Time Prepared: 5/30/2019 11:00 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,222,647	0	0	0	0	1.00
2.00	Land Improvements	688,474	0	0	0	380,891	2.00
3.00	Buildings and Fixtures	29,408,812	1,141,036	0	1,141,036	1,098,497	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	827,895	0	0	0	120,985	5.00
6.00	Movable Equipment	18,953,419	546,554	0	546,554	6,269,549	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	52,101,247	1,687,590	0	1,687,590	7,869,922	8.00
9.00	Reconciling Items	-216,384	-983,479	0	-983,479	-26,969	9.00
10.00	Total (line 8 minus line 9)	52,317,631	2,671,069	0	2,671,069	7,896,891	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,222,647	0	1.00
2.00	Land Improvements	307,583	0	2.00
3.00	Buildings and Fixtures	29,451,351	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	706,910	0	5.00
6.00	Movable Equipment	13,230,424	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	45,918,915	0	8.00
9.00	Reconciling Items	-1,172,894	0	9.00
10.00	Total (line 8 minus line 9)	47,091,809	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part II Date/Time Prepared: 5/30/2019 11:00 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,167,364	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	519,795	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,687,159	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	1,167,364	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	519,795	2.00
3.00	Total (sum of lines 1-2)	0	1,687,159	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 5/30/2019 11:00 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	32,688,491	0	32,688,491	0.711874	127,410	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	13,230,424	0	13,230,424	0.288126	51,568	2.00
3.00	Total (sum of lines 1-2)	45,918,915	0	45,918,915	1.000000	178,978	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	127,410	1,167,364	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	51,568	515,208	0	2.00
3.00	Total (sum of lines 1-2)	0	0	178,978	1,682,572	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	33,919	127,410	0	0	1,328,693	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	14,483	51,568	0	0	581,259	2.00
3.00	Total (sum of lines 1-2)	48,402	178,978	0	0	1,909,952	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/30/2019 11:00 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-683	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-292	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	B	-9,302	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-837	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-4,972	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-27,018	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-5,655,045			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	-88,205			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-254,295	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-1,104	NURSING ADMINISTRATION	13.00	0	17.00
18.00	Sale of medical records and abstracts	B	-42,702	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME	B	-282,902	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/30/2019 11:00 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	POST PT FIT	B	-200	PHYSICAL THERAPY	66.00	0	33.01
34.00	LOBBYING COSTS	A	-13,798	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	MARKETING COSTS - SALARIES	A	-16,925	ADMINISTRATIVE & GENERAL	5.00	0	35.00
35.01	MARKETING COSTS - OTHER EXPENSES	A	-110,887	ADMINISTRATIVE & GENERAL	5.00	0	35.01
35.02	MARKING COSTS - BENEFITS	A	-1,935	ADMINISTRATIVE & GENERAL	5.00	0	35.02
36.00	NON-ALLOWABLE ADVERTISING	A	-1,441	HOME HEALTH AGENCY	101.00	0	36.00
37.00	PROVIDER TAX	A	-2,471,600	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	AMORTIZE EQUIPMENT INSURANCE PROCEED	A	-4,587	CAP REL COSTS-MVBLE EQUIP	2.00	9	38.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,988,730				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: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 5/30/2019 11:00 am

	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	SIHF SERVICES	0	88,205	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			0	88,205	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	SIHF	100.00	SIHF	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: 14-0077	Period: From 01/01/2018 To 12/31/2018	Worksheet A-8-1 Date/Time Prepared: 5/30/2019 11:00 am

	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	-88,205	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-88,205			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	NOT FOR PROFIT		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: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 5/30/2019 11:00 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,274,536	1,244,536	30,000	197,500	228	1.00
2.00	52.00	DELIVERY ROOM & LABOR ROOM	251,800	251,800	0	237,100	0	2.00
3.00	53.00	ANESTHESIOLOGY	927,641	927,641	0	239,400	0	3.00
4.00	65.00	RESPIRATORY THERAPY	87,573	87,573	0	211,500	0	4.00
5.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	72,416	60,416	12,000	181,300	96	5.00
6.00	91.00	EMERGENCY	3,071,096	3,071,096	0	211,500	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			5,685,062	5,643,062	42,000		324	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	21,649	1,082	0	0	0	1.00
2.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	8,368	418	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			30,017	1,500	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	21,649	8,351	1,252,887		1.00
2.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	251,800		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	927,641		3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	87,573		4.00
5.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	8,368	3,632	64,048		5.00
6.00	91.00	EMERGENCY	0	0	0	3,071,096		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	30,017	11,983	5,655,045		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/30/2019 11:00 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,328,693	1,328,693				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	581,259		581,259			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,724,040	15,756	6,893	5,746,689		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,518,350	74,087	32,411	1,159,681	11,784,529	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,000,712	63,814	27,917	142,693	1,235,136	6.00
7.00	00700	OPERATION OF PLANT	1,822,384	199,913	87,455	270,635	2,380,387	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	129,374	10,173	4,450	5,807	149,804	8.00
9.00	00900	HOUSEKEEPING	935,508	19,763	8,646	132,463	1,096,380	9.00
10.00	01000	DIETARY	265,929	56,210	24,590	26,870	373,599	10.00
11.00	01100	CAFETERIA	525,406	20,418	8,932	78,781	633,537	11.00
13.00	01300	NURSING ADMINISTRATION	585,708	32,276	14,120	126,291	758,395	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	159,123	16,748	7,327	34,441	217,639	14.00
15.00	01500	PHARMACY	112,265	14,025	6,136	0	132,426	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	814,011	24,407	10,677	168,699	1,017,794	16.00
17.00	01700	SOCIAL SERVICE	348,129	5,574	2,438	76,358	432,499	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,236,757	357,235	156,277	1,215,868	7,966,137	30.00
43.00	04300	NURSERY	365,447	13,133	5,745	79,586	463,911	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,202,772	114,842	50,240	216,625	1,584,479	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	357,720	7,249	3,171	47,452	415,592	52.00
53.00	05300	ANESTHESIOLOGY	9,668	0	0	0	9,668	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,912,039	34,598	15,136	302,507	2,264,280	54.00
60.00	06000	LABORATORY	2,978,017	35,564	15,558	147,943	3,177,082	60.00
65.00	06500	RESPIRATORY THERAPY	1,052,278	32,722	14,315	174,762	1,274,077	65.00
66.00	06600	PHYSICAL THERAPY	427,232	30,846	13,494	0	471,572	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	202,304	0	0	0	202,304	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	223,682	0	0	0	223,682	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,148,388	0	0	181,697	1,330,085	73.00
74.00	07400	RENAL DIALYSIS	23,905	0	0	0	23,905	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	792,790	46,301	20,255	158,862	1,018,208	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,719,862	99,797	43,658	534,137	3,397,454	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,363,957	0	0	277,046	1,641,003	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	45,867,709	1,325,451	579,841	5,559,204	45,675,564	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,088	0	0	391	2,479	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,405,854	0	0	81,205	3,487,059	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	237,545	0	0	45,918	283,463	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	145,779	3,242	1,418	59,971	210,410	194.01
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)	49,658,975	1,328,693	581,259	5,746,689	49,658,975	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/30/2019 11:00 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,784,529					5.00
6.00	00600	MAINTENANCE & REPAIRS	384,309	1,619,445				6.00
7.00	00700	OPERATION OF PLANT	740,650	275,522	3,396,559			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	46,611	14,020	35,434	245,869		8.00
9.00	00900	HOUSEKEEPING	341,135	27,237	68,838	0	1,533,590	9.00
10.00	01000	DIETARY	116,244	77,469	195,791	0	5,791	10.00
11.00	01100	CAFETERIA	197,123	28,141	71,122	0	20,180	11.00
13.00	01300	NURSING ADMINISTRATION	235,972	44,483	112,425	0	17,329	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	67,718	23,083	58,338	0	17,329	14.00
15.00	01500	PHARMACY	41,204	19,330	48,853	0	8,642	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	316,684	33,639	85,016	0	14,433	16.00
17.00	01700	SOCIAL SERVICE	134,571	7,682	19,414	0	8,642	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,478,649	492,340	1,244,314	120,752	594,619	30.00
43.00	04300	NURSERY	144,345	18,100	45,744	0	14,433	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	493,006	158,277	400,021	7,376	187,545	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	129,310	9,991	25,251	2,183	17,062	52.00
53.00	05300	ANESTHESIOLOGY	3,008	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	704,524	47,684	120,514	36,881	60,585	54.00
60.00	06000	LABORATORY	988,540	49,014	123,876	0	43,300	60.00
65.00	06500	RESPIRATORY THERAPY	396,425	45,098	113,979	2,458	43,300	65.00
66.00	06600	PHYSICAL THERAPY	146,728	42,513	107,444	12,293	63,480	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	62,946	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	69,598	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	413,852	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	7,438	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	316,812	63,813	161,277	0	57,689	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,057,108	137,541	347,615	63,926	288,534	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	510,593	0	0	0	17,329	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,545,103	1,614,977	3,385,266	245,869	1,480,222	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	771	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,084,988	0	0	0	49,047	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	88,199	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	65,468	4,468	11,293	0	4,321	194.01
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)	11,784,529	1,619,445	3,396,559	245,869	1,533,590	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/30/2019 11:00 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	768,894					10.00
11.00	01100	CAFETERIA	0	950,103				11.00
13.00	01300	NURSING ADMINISTRATION	0	25,464	1,194,068			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	13,904	37,199	435,210		14.00
15.00	01500	PHARMACY	0	32,352	0	150	282,957	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	61,395	0	176	0	16.00
17.00	01700	SOCIAL SERVICE	0	21,140	0	6	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	768,894	318,737	423,289	53,722	3,770	30.00
43.00	04300	NURSERY	0	16,200	43,383	2,682	67	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	48,330	127,647	47,644	2,694	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	9,216	24,670	4,576	242	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	4,392	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	73,050	0	10,999	13,305	54.00
60.00	06000	LABORATORY	0	49,597	0	1,822	474	60.00
65.00	06500	RESPIRATORY THERAPY	0	43,643	0	38,087	182	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,480	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	95,820	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	105,944	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	244,258	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	125	71	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	38,956	86,054	12	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	116,376	311,592	57,086	7,520	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	140,234	6,069	104	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	768,894	868,360	1,194,068	430,792	272,687	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	333	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	32,621	0	4,122	10,270	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	18,306	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	0	30,483	0	296	0	194.01
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)	768,894	950,103	1,194,068	435,210	282,957	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/30/2019 11:00 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
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	1,529,137					16.00
17.00	01700	SOCIAL SERVICE	0	623,954				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,376,696	259,791	16,101,710	0	16,101,710	30.00
43.00	04300	NURSERY	4,064	26,626	779,555	0	779,555	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	78,343	3,135,362	0	3,135,362	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	15,141	653,234	0	653,234	52.00
53.00	05300	ANESTHESIOLOGY	0	0	17,068	0	17,068	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	3,331,822	0	3,331,822	54.00
60.00	06000	LABORATORY	0	0	4,433,705	0	4,433,705	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,957,249	0	1,957,249	65.00
66.00	06600	PHYSICAL THERAPY	0	0	845,510	0	845,510	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	361,070	0	361,070	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	399,224	0	399,224	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,988,195	0	1,988,195	73.00
74.00	07400	RENAL DIALYSIS	0	0	31,539	0	31,539	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	52,815	1,795,636	0	1,795,636	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	148,377	191,238	6,124,367	0	6,124,367	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	2,315,332	0	2,315,332	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,529,137	623,954	44,270,578	0	44,270,578	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	3,583	0	3,583	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	4,668,107	0	4,668,107	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	0	389,968	0	389,968	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	0	0	326,739	0	326,739	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,529,137	623,954	49,658,975	0	49,658,975	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/30/2019 11:00 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	11,812	15,756	6,893	34,461	34,461	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	90,970	74,087	32,411	197,468	6,953	5.00
6.00	00600	MAINTENANCE & REPAIRS	4,127	63,814	27,917	95,858	856	6.00
7.00	00700	OPERATION OF PLANT	48,506	199,913	87,455	335,874	1,623	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	10,173	4,450	14,623	35	8.00
9.00	00900	HOUSEKEEPING	0	19,763	8,646	28,409	794	9.00
10.00	01000	DIETARY	0	56,210	24,590	80,800	161	10.00
11.00	01100	CAFETERIA	0	20,418	8,932	29,350	472	11.00
13.00	01300	NURSING ADMINISTRATION	0	32,276	14,120	46,396	757	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	191,360	16,748	7,327	215,435	206	14.00
15.00	01500	PHARMACY	0	14,025	6,136	20,161	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	24,407	10,677	35,084	1,011	16.00
17.00	01700	SOCIAL SERVICE	0	5,574	2,438	8,012	458	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,638	357,235	156,277	523,150	7,296	30.00
43.00	04300	NURSERY	0	13,133	5,745	18,878	477	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	375	114,842	50,240	165,457	1,299	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,249	3,171	10,420	285	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	38,018	34,598	15,136	87,752	1,814	54.00
60.00	06000	LABORATORY	-232	35,564	15,558	50,890	887	60.00
65.00	06500	RESPIRATORY THERAPY	10,119	32,722	14,315	57,156	1,048	65.00
66.00	06600	PHYSICAL THERAPY	0	30,846	13,494	44,340	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,089	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	46,301	20,255	66,556	952	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	99,797	43,658	143,455	3,203	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	784	0	0	784	1,661	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	405,477	1,325,451	579,841	2,310,769	33,337	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	2	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	189,583	0	0	189,583	487	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	0	0	0	275	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	0	3,242	1,418	4,660	360	194.01
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)	595,060	1,328,693	581,259	2,505,012	34,461	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/30/2019 11:00 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	204,421					5.00
6.00	00600	MAINTENANCE & REPAIRS	6,666	103,380				6.00
7.00	00700	OPERATION OF PLANT	12,847	17,588	367,932			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	808	895	3,838	20,199		8.00
9.00	00900	HOUSEKEEPING	5,917	1,739	7,457	0	44,316	9.00
10.00	01000	DIETARY	2,016	4,945	21,209	0	167	10.00
11.00	01100	CAFETERIA	3,419	1,796	7,704	0	583	11.00
13.00	01300	NURSING ADMINISTRATION	4,093	2,840	12,178	0	501	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,175	1,474	6,319	0	501	14.00
15.00	01500	PHARMACY	715	1,234	5,292	0	250	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,493	2,147	9,209	0	417	16.00
17.00	01700	SOCIAL SERVICE	2,334	490	2,103	0	250	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	43,008	31,430	134,793	9,920	17,183	30.00
43.00	04300	NURSERY	2,504	1,155	4,955	0	417	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,551	10,104	43,332	606	5,419	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,243	638	2,735	179	493	52.00
53.00	05300	ANESTHESIOLOGY	52	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,220	3,044	13,055	3,030	1,751	54.00
60.00	06000	LABORATORY	17,147	3,129	13,419	0	1,251	60.00
65.00	06500	RESPIRATORY THERAPY	6,876	2,879	12,347	202	1,251	65.00
66.00	06600	PHYSICAL THERAPY	2,545	2,714	11,639	1,010	1,834	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,092	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,207	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,178	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	129	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	5,495	4,074	17,470	0	1,667	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	18,336	8,780	37,655	5,252	8,338	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	8,856	0	0	0	501	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	182,922	103,095	366,709	20,199	42,774	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,820	0	0	0	1,417	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	1,530	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	1,136	285	1,223	0	125	194.01
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)	204,421	103,380	367,932	20,199	44,316	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/30/2019 11:00 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	109,298					10.00
11.00	01100	CAFETERIA	0	43,324				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,161	67,926			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	634	2,116	227,860		14.00
15.00	01500	PHARMACY	0	1,475	0	79	29,206	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,800	0	92	0	16.00
17.00	01700	SOCIAL SERVICE	0	964	0	3	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	109,298	14,533	24,081	28,127	389	30.00
43.00	04300	NURSERY	0	739	2,468	1,404	7	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,204	7,261	24,945	278	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	420	1,403	2,396	25	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,299	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,331	0	5,759	1,373	54.00
60.00	06000	LABORATORY	0	2,262	0	954	49	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,990	0	19,941	19	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	775	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	50,168	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	55,469	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	25,212	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	65	7	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,776	4,895	6	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	5,307	17,725	29,888	776	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	7,977	3,177	11	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	109,298	39,596	67,926	225,547	28,146	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,488	0	2,158	1,060	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	835	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	0	1,390	0	155	0	194.01
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)	109,298	43,324	67,926	227,860	29,206	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/30/2019 11:00 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
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	56,253					16.00
17.00	01700	SOCIAL SERVICE	0	14,614				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	50,645	6,084	999,937	0	999,937	30.00
43.00	04300	NURSERY	150	624	33,778	0	33,778	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,835	271,291	0	271,291	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	355	21,592	0	21,592	52.00
53.00	05300	ANESTHESIOLOGY	0	0	2,351	0	2,351	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	133,129	0	133,129	54.00
60.00	06000	LABORATORY	0	0	89,988	0	89,988	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	103,709	0	103,709	65.00
66.00	06600	PHYSICAL THERAPY	0	0	64,857	0	64,857	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	51,260	0	51,260	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	56,676	0	56,676	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	33,479	0	33,479	73.00
74.00	07400	RENAL DIALYSIS	0	0	201	0	201	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,237	104,128	0	104,128	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	5,458	4,479	288,652	0	288,652	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	22,967	0	22,967	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	56,253	14,614	2,277,995	0	2,277,995	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	30	0	30	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	215,013	0	215,013	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	0	2,640	0	2,640	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	0	0	9,334	0	9,334	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	56,253	14,614	2,505,012	0	2,505,012	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/30/2019 11:00 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	145,894					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		145,894				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,730	1,730	23,894,174			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,135	8,135	4,821,839	-11,784,529	37,874,446	5.00
6.00	00600	MAINTENANCE & REPAIRS	7,007	7,007	593,302	0	1,235,136	6.00
7.00	00700	OPERATION OF PLANT	21,951	21,951	1,125,274	0	2,380,387	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,117	1,117	24,143	0	149,804	8.00
9.00	00900	HOUSEKEEPING	2,170	2,170	550,769	0	1,096,380	9.00
10.00	01000	DIETARY	6,172	6,172	111,721	0	373,599	10.00
11.00	01100	CAFETERIA	2,242	2,242	327,565	0	633,537	11.00
13.00	01300	NURSING ADMINISTRATION	3,544	3,544	525,107	0	758,395	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,839	1,839	143,202	0	217,639	14.00
15.00	01500	PHARMACY	1,540	1,540	0	0	132,426	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,680	2,680	701,432	0	1,017,794	16.00
17.00	01700	SOCIAL SERVICE	612	612	317,487	0	432,499	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	39,225	39,225	5,055,474	0	7,966,137	30.00
43.00	04300	NURSERY	1,442	1,442	330,910	0	463,911	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,610	12,610	900,706	0	1,584,479	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	796	796	197,300	0	415,592	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	9,668	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,799	3,799	1,257,792	0	2,264,280	54.00
60.00	06000	LABORATORY	3,905	3,905	615,132	0	3,177,082	60.00
65.00	06500	RESPIRATORY THERAPY	3,593	3,593	726,644	0	1,274,077	65.00
66.00	06600	PHYSICAL THERAPY	3,387	3,387	0	0	471,572	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	202,304	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	223,682	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	755,480	0	1,330,085	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	23,905	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	5,084	5,084	660,533	0	1,018,208	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	10,958	10,958	2,220,888	0	3,397,454	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	1,151,929	0	1,641,003	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	145,538	145,538	23,114,629	-11,784,529	33,891,035	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1,626	0	2,479	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	337,643	0	3,487,059	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	0	190,922	0	283,463	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	356	356	249,354	0	210,410	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,328,693	581,259	5,746,689		11,784,529	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.107249	3.984119	0.240506		0.311147	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			34,461		204,421	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001442		0.005397	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: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/30/2019 11:00 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	129,022					6.00
7.00	00700	OPERATION OF PLANT	21,951	107,071				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,117	1,117	192,924			8.00
9.00	00900	HOUSEKEEPING	2,170	2,170	0	34,426		9.00
10.00	01000	DIETARY	6,172	6,172	0	130	34,402	10.00
11.00	01100	CAFETERIA	2,242	2,242	0	453	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,544	3,544	0	389	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,839	1,839	0	389	0	14.00
15.00	01500	PHARMACY	1,540	1,540	0	194	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,680	2,680	0	324	0	16.00
17.00	01700	SOCIAL SERVICE	612	612	0	194	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	39,225	39,225	94,749	13,348	34,402	30.00
43.00	04300	NURSERY	1,442	1,442	0	324	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,610	12,610	5,788	4,210	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	796	796	1,713	383	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,799	3,799	28,939	1,360	0	54.00
60.00	06000	LABORATORY	3,905	3,905	0	972	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,593	3,593	1,929	972	0	65.00
66.00	06600	PHYSICAL THERAPY	3,387	3,387	9,646	1,425	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	5,084	5,084	0	1,295	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	10,958	10,958	50,160	6,477	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	389	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	128,666	106,715	192,924	33,228	34,402	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,101	0	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	356	356	0	97	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,619,445	3,396,559	245,869	1,533,590	768,894	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.551697	31.722493	1.274434	44.547435	22.350270	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	103,380	367,932	20,199	44,316	109,298	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.801259	3.436337	0.104699	1.287283	3.177083	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: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/30/2019 11:00 am

		Cost Center Description	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	59,998					11.00
13.00	01300	NURSING ADMINISTRATION	1,608	251,401				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	878	7,832	918,855			14.00
15.00	01500	PHARMACY	2,043	0	317	483,343		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,877	0	371	0	34,617	16.00
17.00	01700	SOCIAL SERVICE	1,335	0	13	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,128	89,120	113,422	6,439	31,166	30.00
43.00	04300	NURSERY	1,023	9,134	5,662	114	92	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,052	26,875	100,590	4,601	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	582	5,194	9,661	413	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	9,272	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,613	0	23,223	22,727	0	54.00
60.00	06000	LABORATORY	3,132	0	3,847	809	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,756	0	80,412	311	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	3,124	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	202,304	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	223,682	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	417,243	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	264	121	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,460	18,118	25	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	7,349	65,603	120,526	12,845	3,359	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	29,525	12,813	177	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	54,836	251,401	909,528	465,800	34,617	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	21	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,060	0	8,703	17,543	0	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	1,156	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	1,925	0	624	0	0	194.01
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)	950,103	1,194,068	435,210	282,957	1,529,137	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15.835578	4.749655	0.473644	0.585417	44.173007	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	43,324	67,926	227,860	29,206	56,253	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.722091	0.270190	0.247983	0.060425	1.625011	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: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/30/2019 11:00 am

		Cost Center Description	SOCIAL SERVICE (TIME SPENT) 17.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE	214,044		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	89,120		30.00
43.00	04300	NURSERY	9,134		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	26,875		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,194		52.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
60.00	06000	LABORATORY	0		60.00
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
74.00	07400	RENAL DIALYSIS	0		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	18,118		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	65,603		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	214,044		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0		194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	0		194.01
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)	623,954		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.915074		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	14,614		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.068276		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/30/2019 11:00 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,101,710		16,101,710	8,351	16,110,061	30.00
43.00	04300	NURSERY	779,555		779,555	0	779,555	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,135,362		3,135,362	0	3,135,362	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	653,234		653,234	0	653,234	52.00
53.00	05300	ANESTHESIOLOGY	17,068		17,068	0	17,068	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,331,822		3,331,822	0	3,331,822	54.00
60.00	06000	LABORATORY	4,433,705		4,433,705	0	4,433,705	60.00
65.00	06500	RESPIRATORY THERAPY	1,957,249	0	1,957,249	0	1,957,249	65.00
66.00	06600	PHYSICAL THERAPY	845,510	0	845,510	0	845,510	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	361,070		361,070	0	361,070	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	399,224		399,224	0	399,224	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,988,195		1,988,195	0	1,988,195	73.00
74.00	07400	RENAL DIALYSIS	31,539		31,539	0	31,539	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,795,636		1,795,636	3,632	1,799,268	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	6,124,367		6,124,367	0	6,124,367	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,073,489		1,073,489		1,073,489	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,315,332		2,315,332		2,315,332	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	45,344,067	0	45,344,067	11,983	45,356,050	200.00
201.00		Less Observation Beds	1,073,489		1,073,489		1,073,489	201.00
202.00		Total (see instructions)	44,270,578	0	44,270,578	11,983	44,282,561	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/30/2019 11:00 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,308,497		13,308,497			30.00
43.00	04300	NURSERY	60,255		60,255			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	448,902	1,168,482	1,617,384	1.938539	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	80,204	39,476	119,680	5.458172	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	108,692	403,398	512,090	0.033330	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	630,938	6,137,809	6,768,747	0.492236	0.000000	54.00
60.00	06000	LABORATORY	2,221,048	15,325,750	17,546,798	0.252679	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	614,217	1,137,421	1,751,638	1.117382	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	43,292	1,364,009	1,407,301	0.600803	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	228,017	509,506	737,523	0.489571	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	147,906	388,155	536,061	0.744736	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	685,188	519,621	1,204,809	1.650216	0.000000	73.00
74.00	07400	RENAL DIALYSIS	24,720	0	24,720	1.275850	0.000000	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,336,018	1,336,018	1.344021	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	1,016,491	7,746,877	8,763,368	0.698860	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	6,824	522,711	529,535	2.027230	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,957,205	1,957,205			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	19,625,191	38,556,438	58,181,629			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	19,625,191	38,556,438	58,181,629			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/30/2019 11:00 am

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	1.938539	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5.458172	52.00
53.00	05300	ANESTHESIOLOGY	0.033330	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.492236	54.00
60.00	06000	LABORATORY	0.252679	60.00
65.00	06500	RESPIRATORY THERAPY	1.117382	65.00
66.00	06600	PHYSICAL THERAPY	0.600803	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.489571	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.744736	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.650216	73.00
74.00	07400	RENAL DIALYSIS	1.275850	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.346739	76.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.698860	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.027230	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part I Date/Time Prepared: 5/30/2019 11:00 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	999,937	0	999,937	10,475	95.46	30.00
43.00	NURSERY	33,778		33,778	65	519.66	43.00
200.00	Total (lines 30 through 199)	1,033,715		1,033,715	10,540		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	2,069	197,507				30.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	2,069	197,507				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/30/2019 11:00 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	271,291	1,617,384	0.167734	45,646	7,656	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	21,592	119,680	0.180414	3,348	604	52.00
53.00	05300	ANESTHESIOLOGY	2,351	512,090	0.004591	16,123	74	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	133,129	6,768,747	0.019668	154,077	3,030	54.00
60.00	06000	LABORATORY	89,988	17,546,798	0.005128	454,740	2,332	60.00
65.00	06500	RESPIRATORY THERAPY	103,709	1,751,638	0.059207	171,707	10,166	65.00
66.00	06600	PHYSICAL THERAPY	64,857	1,407,301	0.046086	11,998	553	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	51,260	737,523	0.069503	45,641	3,172	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	56,676	536,061	0.105727	60,446	6,391	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,479	1,204,809	0.027788	135,616	3,768	73.00
74.00	07400	RENAL DIALYSIS	201	24,720	0.008131	15,450	126	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	104,128	1,336,018	0.077939	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	288,652	8,763,368	0.032938	244,296	8,047	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	66,630	529,535	0.125827	6,824	859	92.00
200.00		Total (lines 50 through 199)	1,287,943	42,855,672		1,365,912	46,778	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part III Date/Time Prepared: 5/30/2019 11:00 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
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	10,475	0.00	2,069	30.00
43.00	04300	NURSERY		0	65	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	10,540		2,069	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
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: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/30/2019 11:00 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/30/2019 11:00 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	1,617,384	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	119,680	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	512,090	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	6,768,747	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	17,546,798	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,751,638	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,407,301	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	737,523	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	536,061	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,204,809	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	24,720	0.000000	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	1,336,018	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	8,763,368	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	529,535	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	42,855,672		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/30/2019 11:00 am

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	45,646	0	130,958	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	3,348	0	465	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	16,123	0	26,993	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	154,077	0	664,338	0	54.00
60.00	06000	LABORATORY	0.000000	454,740	0	318,367	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	171,707	0	167,720	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	11,998	0	700	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	45,641	0	58,051	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	60,446	0	24,054	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	135,616	0	50,085	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	15,450	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	58,516	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	244,296	0	719,781	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	6,824	0	64,150	0	92.00
200.00		Total (lines 50 through 199)		1,365,912	0	2,284,178	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/30/2019 11:00 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1.938539	130,958	0	0	253,867	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5.458172	465	0	0	2,538	52.00
53.00	05300	ANESTHESIOLOGY	0.033330	26,993	0	0	900	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.492236	664,338	0	0	327,011	54.00
60.00	06000	LABORATORY	0.252679	318,367	0	0	80,445	60.00
65.00	06500	RESPIRATORY THERAPY	1.117382	167,720	0	0	187,407	65.00
66.00	06600	PHYSICAL THERAPY	0.600803	700	0	0	421	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.489571	58,051	0	0	28,420	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.744736	24,054	0	0	17,914	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.650216	50,085	0	1,704	82,651	73.00
74.00	07400	RENAL DIALYSIS	1.275850	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.344021	58,516	0	0	78,647	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.698860	719,781	0	0	503,026	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.027230	64,150	0	0	130,047	92.00
200.00		Subtotal (see instructions)		2,284,178	0	1,704	1,693,294	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		2,284,178	0	1,704	1,693,294	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/30/2019 11:00 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,812		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	2,812		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	2,812		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/30/2019 11:00 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	10,475	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	10,475	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)	9,777	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,069	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)	16,110,061	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)	16,110,061	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)	16,110,061	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,537.95	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,182,019	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3,182,019	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/30/2019 11:00 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	992,545	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,174,564	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)	197,507	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	46,778	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	244,285	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,930,279	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)	698	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,537.95	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,073,489	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/30/2019 11:00 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	999,937	16,110,061	0.062069	1,073,489	66,630	90.00
91.00	Nursing School cost	0	16,110,061	0.000000	1,073,489	0	91.00
92.00	Allied health cost	0	16,110,061	0.000000	1,073,489	0	92.00
93.00	All other Medical Education	0	16,110,061	0.000000	1,073,489	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/30/2019 11:00 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,770,790		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1.938539	45,646	88,487	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5.458172	3,348	18,274	52.00
53.00	05300	ANESTHESIOLOGY	0.033330	16,123	537	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.492236	154,077	75,842	54.00
60.00	06000	LABORATORY	0.252679	454,740	114,903	60.00
65.00	06500	RESPIRATORY THERAPY	1.117382	171,707	191,862	65.00
66.00	06600	PHYSICAL THERAPY	0.600803	11,998	7,208	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.489571	45,641	22,345	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.744736	60,446	45,016	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.650216	135,616	223,796	73.00
74.00	07400	RENAL DIALYSIS	1.275850	15,450	19,712	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.346739	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.698860	244,296	170,729	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.027230	6,824	13,834	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,365,912	992,545	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,365,912		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0077	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/30/2019 11:00 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	2,341,995	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	0	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)	97,483	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)	120.09	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	22.75	30.00
31.00	Percentage of Medicaid patient days (see instructions)	53.50	31.00
32.00	Sum of lines 30 and 31	76.25	32.00
33.00	Allowable disproportionate share percentage (see instructions)	52.12	33.00
34.00	Disproportionate share adjustment (see instructions)	305,162	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0077	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/30/2019 11:00 am
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	6,766,695,164	8,272,872,447	35.00
35.01	Factor 3 (see instructions)	0.000167898	0.000131134	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,136,111	1,084,852	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	849,749	273,442	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,123,191		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 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		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	3,867,831		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)	3,867,831	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	235,016	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)	4,102,847	59.00
60.00	Primary payer payments	4,000	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	4,098,847	61.00
62.00	Deductibles billed to program beneficiaries	365,724	62.00
63.00	Coinsurance billed to program beneficiaries	24,060	63.00
64.00	Allowable bad debts (see instructions)	394,414	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	256,369	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	225,647	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	3,965,432	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)		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)	15,915	70.93
70.94	HRR adjustment amount (see instructions)	-5,283	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0077	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/30/2019 11:00 am
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		3,976,064	71.00
71.01	Sequestration adjustment (see instructions)		79,521	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		3,868,488	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)		28,055	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	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
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0077	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/30/2019 11:00 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	2,812	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	1,693,294	2.00
3.00	OPPS payments	806,660	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	2,812	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	1,704	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)	1,704	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	1,704	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	1,108	20.00
21.00	Lesser of cost or charges (see instructions)	1,704	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)	806,660	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	184,837	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)	623,527	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)	623,527	30.00
31.00	Primary payer payments	180	31.00
32.00	Subtotal (line 30 minus line 31)	623,347	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)	207,921	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	135,149	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	113,207	36.00
37.00	Subtotal (see instructions)	758,496	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	758,496	40.00
40.01	Sequestration adjustment (see instructions)	15,170	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	710,031	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	33,295	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: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/30/2019 11:00 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,868,488		710,031	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)		3,868,488		710,031	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		28,055		33,295	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,896,543		743,326	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: 14-0077	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/30/2019 11:00 am
	Title XVIII	Hospital	PPS

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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G | Date/Time Prepared: 5/30/2019 11:00 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	5,399,005	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	3,873,960	0	0	0	4.00
5.00	Other receivable	352,521	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	405,502	0	0	0	7.00
8.00	Prepaid expenses	523,141	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	10,554,129	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,222,647	0	0	0	12.00
13.00	Land improvements	307,583	0	0	0	13.00
14.00	Accumulated depreciation	-260,229	0	0	0	14.00
15.00	Buildings	29,451,351	0	0	0	15.00
16.00	Accumulated depreciation	-14,981,880	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	13,937,334	0	0	0	19.00
20.00	Accumulated depreciation	-11,665,808	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	1,172,894	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	20,183,892	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	895,239	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	895,239	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	31,633,260	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,626,662	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,541,146	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,000,413	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	505,332	0	0	0	43.00
44.00	Other current liabilities	677,945	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,351,498	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	8,580,686	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	2,828,284	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	11,408,970	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	19,760,468	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	11,872,792				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	11,872,792	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	31,633,260	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 5/30/2019 11:00 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		14,057,898		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-2,347,361				2.00
3.00	Total (sum of line 1 and line 2)		11,710,537		0		3.00
4.00	RESTRICTED GRANTS	144,231		0		0	4.00
5.00	CONTRIBUTIONS FROM SOUTHERN ILLINOIS	18,015		0		0	5.00
6.00	ROUNDING	9		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)		162,255		0		10.00
11.00	Subtotal (line 3 plus line 10)		11,872,792		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)		11,872,792		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	RESTRICTED GRANTS		0		4.00
5.00	CONTRIBUTIONS FROM SOUTHERN ILLINOIS		0		5.00
6.00	ROUNDING		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: 14-0077 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/30/2019 11:00 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	13,368,752		13,368,752	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)	13,368,752		13,368,752	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	13,368,752		13,368,752	17.00
18.00	Ancillary services	5,233,125	28,329,644	33,562,769	18.00
19.00	Outpatient services	1,023,315	8,269,588	9,292,903	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,957,205	1,957,205	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIANS' PRIVATE OFFICES	1,603,807	8,204,224	9,808,031	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	21,228,999	46,760,661	67,989,660	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		58,647,705		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)		58,647,705		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-0077	Period: From 01/01/2018 To 12/31/2018	Worksheet G-3 Date/Time Prepared: 5/30/2019 11:00 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	67,989,660	1.00
2.00	Less contractual allowances and discounts on patients' accounts	12,601,480	2.00
3.00	Net patient revenues (line 1 minus line 2)	55,388,180	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	58,647,705	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,259,525	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	165,859	6.00
7.00	Income from investments	10,277	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	837	10.00
11.00	Rebates and refunds of expenses	4,972	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	254,295	14.00
15.00	Revenue from rental of living quarters	24,055	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	42,702	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	17,172	22.00
23.00	Governmental appropriations	0	23.00
24.00	RELATED PARTY	88,205	24.00
24.01	GAIN ON INVESTMENT	8,210	24.01
24.02	PHYSICIAN UNIVERSITY ROTATIONS	12,000	24.02
24.03	MISCELLANEOUS	285,342	24.03
25.00	Total other income (sum of lines 6-24)	913,926	25.00
26.00	Total (line 5 plus line 25)	-2,345,599	26.00
27.00	LOSS ON DISPOSAL OF ASSETS	1,762	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	1,762	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-2,347,361	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0077 | HHA CCN: 14-7315 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H | Date/Time Prepared: 5/30/2019 11:00 am

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		784	784	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	283,648	21,373	24,769	0	49,637	379,427	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	470,551	35,456	31,314	0	0	537,321	6.00
7.00	Physical Therapy	268,219	20,211	13,411	0	0	301,841	7.00
8.00	Occupational Therapy	113,275	8,535	5,971	0	0	127,781	8.00
9.00	Speech Pathology	12,825	966	519	0	0	14,310	9.00
10.00	Medical Social Services	3,411	257	89	0	0	3,757	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	177	177	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,151,929	86,798	76,073	0	50,598	1,365,398	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	784	0	784			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	379,427	-1,441	377,986			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	537,321	0	537,321			6.00
7.00	Physical Therapy	0	301,841	0	301,841			7.00
8.00	Occupational Therapy	0	127,781	0	127,781			8.00
9.00	Speech Pathology	0	14,310	0	14,310			9.00
10.00	Medical Social Services	0	3,757	0	3,757			10.00
11.00	Home Health Aide	0	0	0	0			11.00
12.00	Supplies (see instructions)	0	177	0	177			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	0	1,365,398	-1,441	1,363,957			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 14-0077
HHA CCN: 14-7315

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

Worksheet H-1 Part I
Date/Time Prepared: 5/30/2019 11:00 am

Home Health Agency I

PPS

			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	784	784				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	377,986	784	0	0	0	378,770	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	537,321	0	0	0	0	537,321	6.00
7.00	Physical Therapy	301,841	0	0	0	0	301,841	7.00
8.00	Occupational Therapy	127,781	0	0	0	0	127,781	8.00
9.00	Speech Pathology	14,310	0	0	0	0	14,310	9.00
10.00	Medical Social Services	3,757	0	0	0	0	3,757	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	177	0	0	0	0	177	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,363,957	784	0	0	0	1,363,957	24.00

		Administrative & General	Total (cols. 4A + 5)		
		5.00	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related - Bldg. & Fixtures				1.00
2.00	Capital Related - Movable Equipment				2.00
3.00	Plant Operation & Maintenance				3.00
4.00	Transportation				4.00
5.00	Administrative and General	378,770			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	206,582	743,903		6.00
7.00	Physical Therapy	116,047	417,888		7.00
8.00	Occupational Therapy	49,127	176,908		8.00
9.00	Speech Pathology	5,502	19,812		9.00
10.00	Medical Social Services	1,444	5,201		10.00
11.00	Home Health Aide	0	0		11.00
12.00	Supplies (see instructions)	68	245		12.00
13.00	Drugs	0	0		13.00
14.00	DME	0	0		14.00
	HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0		15.00
16.00	Respiratory Therapy	0	0		16.00
17.00	Private Duty Nursing	0	0		17.00
18.00	Clinic	0	0		18.00
19.00	Health Promotion Activities	0	0		19.00
20.00	Day Care Program	0	0		20.00
21.00	Home Delivered Meals Program	0	0		21.00
22.00	Homemaker Service	0	0		22.00
23.00	All Others (specify)	0	0		23.00
23.50	Telemedicine	0	0		23.50
24.00	Total (sum of lines 1-23)		1,363,957		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 14-0077 | HHA CCN: 14-7315 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-1 Part II | Date/Time Prepared: 5/30/2019 11:00 am

Home Health Agency I | PPS

		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	784				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	784	0	0	0	-378,770	985,187	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	537,321	6.00
7.00	Physical Therapy	0	0	0	0	0	301,841	7.00
8.00	Occupational Therapy	0	0	0	0	0	127,781	8.00
9.00	Speech Pathology	0	0	0	0	0	14,310	9.00
10.00	Medical Social Services	0	0	0	0	0	3,757	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	177	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	784	0	0	0	-378,770	985,187	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	784	0	0	0		378,770	25.00
26.00	Unit Cost Multiplier	1.000000	0.000000	0.000000	0.000000		0.384465	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0077 HHA CCN: 14-7315

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

Worksheet H-2 Part I Date/Time Prepared: 5/30/2019 11:00 am

Home Health Agency I

PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	0	0	68,219	68,219	21,226	1.00
2.00	Skilled Nursing Care	743,903	0	0	113,172	857,075	266,677	2.00
3.00	Physical Therapy	417,888	0	0	64,508	482,396	150,096	3.00
4.00	Occupational Therapy	176,908	0	0	27,243	204,151	63,521	4.00
5.00	Speech Pathology	19,812	0	0	3,084	22,896	7,124	5.00
6.00	Medical Social Services	5,201	0	0	820	6,021	1,873	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	245	0	0	0	245	76	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,363,957	0	0	277,046	1,641,003	510,593	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	0	0	0	17,329	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	17,329	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0077 | HHA CCN: 14-7315 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-2 Part I | Date/Time Prepared: 5/30/2019 11:00 am

Home Health Agency I | PPS

	Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
		13.00	14.00	15.00	16.00	17.00	24.00	
1.00	Administrative and General	45,663	6,069	0	0	0	158,506	1.00
2.00	Skilled Nursing Care	57,723	0	0	0	0	1,181,475	2.00
3.00	Physical Therapy	24,722	0	0	0	0	657,214	3.00
4.00	Occupational Therapy	11,005	0	0	0	0	278,677	4.00
5.00	Speech Pathology	955	0	0	0	0	30,975	5.00
6.00	Medical Social Services	166	0	0	0	0	8,060	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	321	8.00
9.00	Drugs	0	0	104	0	0	104	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	140,234	6,069	104	0	0	2,315,332	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		25.00	26.00	27.00	28.00			
1.00	Administrative and General	0	158,506					1.00
2.00	Skilled Nursing Care	0	1,181,475	86,827	1,268,302			2.00
3.00	Physical Therapy	0	657,214	48,299	705,513			3.00
4.00	Occupational Therapy	0	278,677	20,480	299,157			4.00
5.00	Speech Pathology	0	30,975	2,276	33,251			5.00
6.00	Medical Social Services	0	8,060	592	8,652			6.00
7.00	Home Health Aide	0	0	0	0			7.00
8.00	Supplies (see instructions)	0	321	24	345			8.00
9.00	Drugs	0	104	8	112			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
19.50	Telemedicine	0	0	0	0			19.50
20.00	Total (sum of lines 1-19) (2)	0	2,315,332	158,506	2,315,332			20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.073490				21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0077 HHA CCN: 14-7315

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

Worksheet H-2 Part II Date/Time Prepared: 5/30/2019 11:00 am

Home Health Agency I

PPS

	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	6.00	
1.00	Administrative and General	0	0	283,648	0	68,219	0	1.00
2.00	Skilled Nursing Care	0	0	470,551	0	857,075	0	2.00
3.00	Physical Therapy	0	0	268,219	0	482,396	0	3.00
4.00	Occupational Therapy	0	0	113,275	0	204,151	0	4.00
5.00	Speech Pathology	0	0	12,825	0	22,896	0	5.00
6.00	Medical Social Services	0	0	3,411	0	6,021	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	245	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	1,151,929		1,641,003	0	20.00
21.00	Total cost to be allocated	0	0	277,046		510,593	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.240506		0.311147	0.000000	22.00

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	0	0	389	0	0	9,614	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	12,153	2.00
3.00	Physical Therapy	0	0	0	0	0	5,205	3.00
4.00	Occupational Therapy	0	0	0	0	0	2,317	4.00
5.00	Speech Pathology	0	0	0	0	0	201	5.00
6.00	Medical Social Services	0	0	0	0	0	35	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	389	0	0	29,525	20.00
21.00	Total cost to be allocated	0	0	17,329	0	0	140,234	21.00
22.00	Unit cost multiplier	0.000000	0.000000	44.547558	0.000000	0.000000	4.749670	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0077
HHA CCN: 14-7315

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

Worksheet H-2 Part II
Date/Time Prepared: 5/30/2019 11:00 am

Home Health Agency I

PPS

	Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)			
		14.00	15.00	16.00	17.00			
1.00	Administrative and General	12,813	0	0	0			1.00
2.00	Skilled Nursing Care	0	0	0	0			2.00
3.00	Physical Therapy	0	0	0	0			3.00
4.00	Occupational Therapy	0	0	0	0			4.00
5.00	Speech Pathology	0	0	0	0			5.00
6.00	Medical Social Services	0	0	0	0			6.00
7.00	Home Health Aide	0	0	0	0			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	0	177	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
19.50	Telemedicine	0	0	0	0			19.50
20.00	Total (sum of lines 1-19)	12,813	177	0	0			20.00
21.00	Total cost to be allocated	6,069	104	0	0			21.00
22.00	Unit cost multiplier	0.473660	0.587571	0.000000	0.000000			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 14-0077 | HHA CCN: 14-7315 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-3 Part I | Date/Time Prepared: 5/30/2019 11:00 am

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	1,268,302		1,268,302	4,914	258.10	1.00
2.00	Physical Therapy	3.00	705,513	0	705,513	3,984	177.09	2.00
3.00	Occupational Therapy	4.00	299,157	0	299,157	1,876	159.47	3.00
4.00	Speech Pathology	5.00	33,251	0	33,251	125	266.01	4.00
5.00	Medical Social Services	6.00	8,652		8,652	25	346.08	5.00
6.00	Home Health Aide	7.00	0		0	0	0.00	6.00
7.00	Total (sum of lines 1-6)		2,314,875	0	2,314,875	10,924		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		41180	0	500			8.00
9.00	Physical Therapy		41180	0	539			9.00
10.00	Occupational Therapy		41180	0	245			10.00
11.00	Speech Pathology		41180	0	33			11.00
12.00	Medical Social Services		41180	0	12			12.00
13.00	Home Health Aide		41180	0	0			13.00
14.00	Total (sum of lines 8-13)			0	1,329			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	345	0	345	158	2.183544	15.00
16.00	Cost of Drugs	9.00	112	0	112	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	500		0	129,050		1.00
2.00	Physical Therapy	0	539		0	95,452		2.00
3.00	Occupational Therapy	0	245		0	39,070		3.00
4.00	Speech Pathology	0	33		0	8,778		4.00
5.00	Medical Social Services	0	12		0	4,153		5.00
6.00	Home Health Aide	0	0		0	0		6.00
7.00	Total (sum of lines 1-6)	0	1,329		0	276,503		7.00

	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0077 | HHA CCN: 14-7315 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-3 Part I | Date/Time Prepared: 5/30/2019 11:00 am

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	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	158	0	0	345	0	15.00
16.00	Cost of Drugs	0	0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	129,050	1.00
2.00	Physical Therapy	95,452	2.00
3.00	Occupational Therapy	39,070	3.00
4.00	Speech Pathology	8,778	4.00
5.00	Medical Social Services	4,153	5.00
6.00	Home Health Aide	0	6.00
7.00	Total (sum of lines 1-6)	276,503	7.00

	Cost Center Description		
		12.00	
	Limitation Cost Computation		
8.00	Skilled Nursing Care		8.00
9.00	Physical Therapy		9.00
10.00	Occupational Therapy		10.00
11.00	Speech Pathology		11.00
12.00	Medical Social Services		12.00
13.00	Home Health Aide		13.00
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0077
HHA CCN: 14-7315

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

Worksheet H-3
Part II
Date/Time Prepared:
5/30/2019 11:00 am

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.600803	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy							2.00
3.00	Speech Pathology							3.00
4.00	Cost of Medical Supplies	71.00	0.489571	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	1.650216	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0077 | HHA CCN: 14-7315 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-4 Part I-II | Date/Time Prepared: 5/30/2019 11:00 am

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	218,081	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	4,993	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	5,457	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	987	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	0	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	229,518	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	229,518	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	229,518	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	229,518	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	229,518	31.00
31.01	Sequestration adjustment (see instructions)	0	0	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	229,518	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

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

Provider CCN: 14-0077 | HHA CCN: 14-7315 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-5 | Date/Time Prepared: 5/30/2019 11:00 am

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		229,518	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		229,518	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		229,518	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0077	Period: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III Date/Time Prepared: 5/30/2019 11:00 am
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		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	193,185	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	9,569	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	26.88	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	22.75	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	53.50	8.00
9.00	Sum of lines 7 and 8	76.25	9.00
10.00	Allowable disproportionate share percentage (see instructions)	16.70	10.00
11.00	Disproportionate share adjustment (see instructions)	32,262	11.00
12.00	Total prospective capital payments (see instructions)	235,016	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00