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: 14-0118	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/30/2019 4:56 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/30/2019 Time: 4:56 pm
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 METROSOUTH MEDICAL CENTER (14-0118) 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) JOSEPH MARINO
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	387,137	268,118	0	0	1.00
2.00	Subprovider - IPF	0	52,605	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	439,742	268,118	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: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2019 4:56 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 12935 SOUTH GREGORY STREET	PO Box:			1.00
2.00	City: BLUE ISLAND	State: IL	Zip Code: 60406	County: COOK	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	METROSOUTH MEDICAL CENTER	140118	16974	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	METRO SOUTH PSYCH UNIT	14S118	16974	4	01/01/2013	N	P	O	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									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)	4		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.	2	N		23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	2,471	1,807	34	46	7,045	148	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2019 4:56 pm

		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.				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: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2019 4:56 pm

		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: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2019 4:56 pm

		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.	Y			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0118	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/30/2019 4:56 pm

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0118	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/30/2019 4:56 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	108,438	6,021	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	HB0776	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2019 4:56 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: QUORUM HEALTH CORPORATION	Contractor's Name: WPS	Contractor's Number: 52280	141.00
142.00	Street: 1573 MALLORY LAND	PO Box: SUITE 100		142.00
143.00	City: BRENTWOOD	State: TN	Zip Code: 37027	143.00

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

		1.00	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	N	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)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2018	12/31/2018	170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 5/30/2019 4:56 pm

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	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	03/20/2019	Y	03/20/2019
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: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 5/30/2019 4:56 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MORAN		JOSEPH		41.00
42.00	Enter the employer/company name of the cost report preparer.	QUORUM HEALTHCARE				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615.221.3613		JOSEPH_MORAN@QUORUMHEALTH.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0118	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/30/2019 4:56 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER, REIMBURSEMENT		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: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I Date/Time Prepared: 5/30/2019 4:56 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	264	96,360	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)		264	96,360	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	36	13,140	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		300	109,500	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	14	5,110		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		314				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: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2019 4:56 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	8,534	1,204	24,676			1.00
2.00	HMO and other (see instructions)	4,652	8,631				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)	8,534	1,204	24,676			7.00
8.00	INTENSIVE CARE UNIT	1,068	96	2,804			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		1,472	1,866			13.00
14.00	Total (see instructions)	9,602	2,772	29,346	0.00	670.21	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	2,087	0	3,718	0.00	22.73	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	692.94	27.00
28.00	Observation Bed Days		0	4,458			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	148	217			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: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2019 4:56 pm

	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	2,055	2,364	7,495	1.00
2.00	HMO and other (see instructions)			959	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	2,055	2,364	7,495	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	213	46	402	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part II Date/Time Prepared: 5/30/2019 4:56 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	47,689,297	0	47,689,297	1,441,318.00	33.09	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		1,532,765	176,725	1,709,490	52,846.00	32.35	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		4,445,788	0	4,445,788	65,607.00	67.76	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		271,970	0	271,970	2,687.00	101.22	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		1,519,389	0	1,519,389	20,735.00	73.28	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		9,537,065	0	9,537,065			17.00
18.00	Wage-related costs (other) (see instructions)		20,519	0	20,519			18.00
19.00	Excluded areas		366,928	0	366,928			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		0	0	0			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	524,572	0	524,572	11,649.00	45.03	26.00
27.00	Administrative & General	5.00	5,029,216	-432,068	4,597,148	148,985.00	30.86	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part II Date/Time Prepared: 5/30/2019 4:56 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		545,124	0	545,124	6,875.00	79.29	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,150,073	0	1,150,073	28,968.00	39.70	30.00
31.00	Laundry & Linen Service	8.00	141,268	0	141,268	7,966.00	17.73	31.00
32.00	Housekeeping	9.00	1,532,759	0	1,532,759	97,048.00	15.79	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		2,285,659	0	2,285,659	86,445.00	26.44	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,468,541	255,343	2,723,884	55,866.00	48.76	38.00
39.00	Central Services and Supply	14.00	455,101	0	455,101	22,114.00	20.58	39.00
40.00	Pharmacy	15.00	1,629,926	0	1,629,926	37,697.00	43.24	40.00
41.00	Medical Records & Medical Records Library	16.00	572,059	0	572,059	22,094.00	25.89	41.00
42.00	Social Service	17.00	1,201	0	1,201	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part III Date/Time Prepared: 5/30/2019 4:56 pm

		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)		50,520,080	0	50,520,080	1,534,638.00	32.92	1.00
2.00	Excluded area salaries (see instructions)		1,532,765	176,725	1,709,490	52,846.00	32.35	2.00
3.00	Subtotal salaries (line 1 minus line 2)		48,987,315	-176,725	48,810,590	1,481,792.00	32.94	3.00
4.00	Subtotal other wages & related costs (see inst.)		6,237,147	0	6,237,147	89,029.00	70.06	4.00
5.00	Subtotal wage-related costs (see inst.)		9,557,584	0	9,557,584	0.00	19.58	5.00
6.00	Total (sum of lines 3 thru 5)		64,782,046	-176,725	64,605,321	1,570,821.00	41.13	6.00
7.00	Total overhead cost (see instructions)		16,335,499	-176,725	16,158,774	525,707.00	30.74	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part IV Date/Time Prepared: 5/30/2019 4:56 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	922,003	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)	4,360,679	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	159,495	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	36,116	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)	140,100	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	374,678	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	2,787,820	17.00
18.00	Medicare Taxes - Employers Portion Only	651,990	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	450,594	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	9,883,475	24.00
	Part B - Other than Core Related Cost		
25.00	BENEFITS - OTHER	20,519	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part V Date/Time Prepared: 5/30/2019 4:56 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	4,445,788	9,883,475	1.00
2.00	Hospital	4,445,788	9,883,475	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-10 | Date/Time Prepared: 5/30/2019 4:56 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.134506	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	19,438,060	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	13,605,326	5.00
6.00	Medicaid charges	263,039,523	6.00
7.00	Medicaid cost (line 1 times line 6)	35,380,394	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	2,337,008	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,337,008	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)	11,460,029	9,213	11,469,242	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,541,443	3,605	1,545,048	21.00
22.00	Payments received from patients for amounts previously written off as charity care	232,309	695	233,004	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,309,134	2,910	1,312,044	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?	Y	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	6,479	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	21,491,139	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	908,292	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,397,373	27.01
28.00	Non-Medicare bad debt expense (see instructions)	20,093,766	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	3,191,813	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	4,503,857	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,840,865	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/30/2019 4:56 pm

		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		1,457,510	1,457,510	2,115,893	3,573,403	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,888,634	3,888,634	1,766,126	5,654,760	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	524,572	213,649	738,221	6,007,293	6,745,514	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,029,216	33,939,541	38,968,757	-8,596,202	30,372,555	5.00
7.00	00700	OPERATION OF PLANT	1,150,073	4,631,981	5,782,054	-498	5,781,556	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	141,268	572,072	713,340	0	713,340	8.00
9.00	00900	HOUSEKEEPING	1,532,759	438,040	1,970,799	0	1,970,799	9.00
10.00	01000	DIETARY	0	2,271,166	2,271,166	-522	2,270,644	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,468,541	855,587	3,324,128	234,345	3,558,473	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	455,101	8,474,522	8,929,623	-7,927,316	1,002,307	14.00
15.00	01500	PHARMACY	1,629,926	3,143,554	4,773,480	-2,260,281	2,513,199	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	572,059	1,346,201	1,918,260	0	1,918,260	16.00
17.00	01700	SOCIAL SERVICE	1,201	92	1,293	0	1,293	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,946,277	5,068,137	16,014,414	-25,130	15,989,284	30.00
31.00	03100	INTENSIVE CARE UNIT	1,811,609	1,472,314	3,283,923	-98,998	3,184,925	31.00
40.00	04000	SUBPROVIDER - IPF	1,478,026	428,171	1,906,197	-2,028	1,904,169	40.00
43.00	04300	NURSERY	1,385,164	1,099,067	2,484,231	-6,950	2,477,281	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,630,205	2,031,000	4,661,205	-264,400	4,396,805	50.00
51.00	05100	RECOVERY ROOM	669,491	69,529	739,020	0	739,020	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,859,688	2,436,296	4,295,984	-5,576	4,290,408	52.00
53.00	05300	ANESTHESIOLOGY	66,015	3,027,507	3,093,522	0	3,093,522	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,677,038	1,515,643	3,192,681	-9,836	3,182,845	54.00
54.01	05401	ULTRASOUND	520,638	81,893	602,531	0	602,531	54.01
56.00	05600	RADIOISOTOPE	263,634	438,084	701,718	0	701,718	56.00
57.00	05700	CT SCAN	596,430	284,455	880,885	0	880,885	57.00
58.00	05800	MRI	238,758	106,556	345,314	0	345,314	58.00
60.00	06000	LABORATORY	2,438,778	2,782,310	5,221,088	-214,925	5,006,163	60.00
65.00	06500	RESPIRATORY THERAPY	917,228	406,210	1,323,438	-147,095	1,176,343	65.00
66.00	06600	PHYSICAL THERAPY	833,117	86,097	919,214	-120,600	798,614	66.00
67.00	06700	OCCUPATIONAL THERAPY	92,094	8,884	100,978	39,433	140,411	67.00
68.00	06800	SPEECH PATHOLOGY	174,877	29,662	204,539	72,521	277,060	68.00
69.00	06900	ELECTROCARDIOLOGY	1,972,957	854,186	2,827,143	-5,108	2,822,035	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,701,178	2,701,178	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,510,268	4,510,268	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,037,441	2,037,441	73.00
74.00	07400	RENAL DIALYSIS	0	1,034,672	1,034,672	0	1,034,672	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,557,818	4,362,601	7,920,419	-5,226	7,915,193	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	47,634,558	88,855,823	136,490,381	-206,193	136,284,188	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	197,463	197,463	-195,101	2,362	192.00
194.00	07954	OTHER NONREIMBURSABLE COSTS	0	9,963	9,963	0	9,963	194.00
194.01	07951	MARKETING	0	0	0	401,294	401,294	194.01
194.02	07953	SENIOR CIRCLE	54,739	16,929	71,668	0	71,668	194.02
194.03	07952	MOB	0	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	47,689,297	89,080,178	136,769,475	0	136,769,475	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/30/2019 4:56 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-500,648	3,072,755		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-1,411,630	4,243,130		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-10,054	6,735,460		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-13,308,279	17,064,276		5.00
7.00	00700	OPERATION OF PLANT	0	5,781,556		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	713,340		8.00
9.00	00900	HOUSEKEEPING	0	1,970,799		9.00
10.00	01000	DIETARY	0	2,270,644		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	-180	3,558,293		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,002,307		14.00
15.00	01500	PHARMACY	0	2,513,199		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,784	1,916,476		16.00
17.00	01700	SOCIAL SERVICE	0	1,293		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,753,392	14,235,892		30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,184,925		31.00
40.00	04000	SUBPROVIDER - IPF	-18,926	1,885,243		40.00
43.00	04300	NURSERY	-735,819	1,741,462		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	4,396,805		50.00
51.00	05100	RECOVERY ROOM	0	739,020		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-1,643,496	2,646,912		52.00
53.00	05300	ANESTHESIOLOGY	-2,904,510	189,012		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-684,003	2,498,842		54.00
54.01	05401	ULTRASOUND	0	602,531		54.01
56.00	05600	RADIOISOTOPE	-31,920	669,798		56.00
57.00	05700	CT SCAN	0	880,885		57.00
58.00	05800	MRI	0	345,314		58.00
60.00	06000	LABORATORY	-25,200	4,980,963		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,176,343		65.00
66.00	06600	PHYSICAL THERAPY	0	798,614		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	140,411		67.00
68.00	06800	SPEECH PATHOLOGY	0	277,060		68.00
69.00	06900	ELECTROCARDIOLOGY	-57,813	2,764,222		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,701,178		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,510,268		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-3,837	2,033,604		73.00
74.00	07400	RENAL DIALYSIS	0	1,034,672		74.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-1,808,319	6,106,874		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-24,899,810	111,384,378		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,362		192.00
194.00	07954	OTHER NONREIMBURSABLE COSTS	0	9,963		194.00
194.01	07951	MARKETING	0	401,294		194.01
194.02	07953	SENIOR CIRCLE	0	71,668		194.02
194.03	07952	MOB	0	0		194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-24,899,810	111,869,665		200.00

RECLASSIFICATIONS | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/30/2019 4:56 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6,007,293	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
	0		0	6,007,293	
	B - OXYGEN COSTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	114,554	1.00
2.00	OPERATION OF PLANT	7.00	0	344	2.00
	0		0	114,898	
	C - RENTAL AND LEASE EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	250,693	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,760,831	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
	0		0	2,011,524	
	D - OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	201,331	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,663,869	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	5,295	3.00
	0		0	1,870,495	
	E - MARKETING DEPARTMENT				
1.00	MARKETING	194.01	176,725	224,569	1.00
	0		176,725	224,569	
	F - CHIEF NURSING OFFICER				
1.00	NURSING ADMINISTRATION	13.00	255,343	0	1.00
	0		255,343	0	
	G - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,586,624	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	4,510,268	2.00
3.00	OPERATING ROOM	50.00	0	88,893	3.00
	0		0	7,185,785	
	H - COSTS OF DRUGS/IV SOLUTIONS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,037,441	1.00
	0		0	2,037,441	
	I - PT, OT, SP COSTS				
1.00	OCCUPATIONAL THERAPY	67.00	34,018	5,415	1.00
2.00	SPEECH PATHOLOGY	68.00	81,766	0	2.00
	0		115,784	5,415	
500.00	Grand Total: Increases		547,852	19,457,420	500.00

RECLASSIFICATIONS | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/30/2019 4:56 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,002,280	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	4,898	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	40	0		3.00
4.00	ELECTROCARDIOLOGY	69.00	0	75	0		4.00
	0		0	6,007,293			
	B - OXYGEN COSTS						
1.00	OPERATING ROOM	50.00	0	97	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	114,801	0		2.00
	0		0	114,898			
	C - RENTAL AND LEASE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	66,790	10		1.00
2.00	OPERATION OF PLANT	7.00	0	842	10		2.00
3.00	DIETARY	10.00	0	522	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	16,100	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	744,868	0		5.00
6.00	PHARMACY	15.00	0	222,840	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	25,090	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	98,998	0		8.00
9.00	SUBPROVIDER - IPF	40.00	0	2,028	0		9.00
10.00	NURSERY	43.00	0	6,950	0		10.00
11.00	OPERATING ROOM	50.00	0	353,196	0		11.00
12.00	DELIVERY ROOM & LABOR ROOM	52.00	0	5,576	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	9,836	0		13.00
14.00	LABORATORY	60.00	0	214,925	0		14.00
15.00	RESPIRATORY THERAPY	65.00	0	32,294	0		15.00
16.00	PHYSICAL THERAPY	66.00	0	52	0		16.00
17.00	SPEECH PATHOLOGY	68.00	0	8,594	0		17.00
18.00	ELECTROCARDIOLOGY	69.00	0	1,696	0		18.00
19.00	EMERGENCY	91.00	0	5,226	0		19.00
20.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	195,101	0		20.00
	0		0	2,011,524			
	D - OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,870,495	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	0		0	1,870,495			
	E - MARKETING DEPARTMENT						
1.00	ADMINISTRATIVE & GENERAL	5.00	176,725	224,569	0		1.00
	0		176,725	224,569			
	F - CHIEF NURSING OFFICER						
1.00	ADMINISTRATIVE & GENERAL	5.00	255,343	0	0		1.00
	0		255,343	0			
	G - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	7,182,448	0		1.00
2.00	ELECTROCARDIOLOGY	69.00	0	3,337	0		2.00
3.00		0.00	0	0	0		3.00
	0		0	7,185,785			
	H - COSTS OF DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	2,037,441	0		1.00
	0		0	2,037,441			
	I - PT, OT, SP COSTS						
1.00	PHYSICAL THERAPY	66.00	115,784	4,764	0		1.00
2.00	SPEECH PATHOLOGY	68.00	0	651	0		2.00
	0		115,784	5,415			
500.00	Grand Total: Decreases		547,852	19,457,420			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part I | Date/Time Prepared: 5/30/2019 4:56 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	43,275	0	0	0	0	2.00
3.00	Buildings and Fixtures	96,813	3,381	0	3,381	0	3.00
4.00	Building Improvements	7,887,064	234,461	0	234,461	32,687	4.00
5.00	Fixed Equipment	2,112,854	9,458	0	9,458	0	5.00
6.00	Movable Equipment	22,498,485	266,520	0	266,520	10,849	6.00
7.00	HIT designated Assets	14,055,496	13,700	0	13,700	433,340	7.00
8.00	Subtotal (sum of lines 1-7)	46,693,987	527,520	0	527,520	476,876	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	46,693,987	527,520	0	527,520	476,876	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	43,275	0	2.00
3.00	Buildings and Fixtures	100,194	0	3.00
4.00	Building Improvements	8,088,838	0	4.00
5.00	Fixed Equipment	2,122,312	0	5.00
6.00	Movable Equipment	22,754,156	0	6.00
7.00	HIT designated Assets	13,635,856	0	7.00
8.00	Subtotal (sum of lines 1-7)	46,744,631	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	46,744,631	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part II | Date/Time Prepared: 5/30/2019 4:56 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,457,510	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,888,634	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,346,144	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	1,457,510		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,888,634		2.00
3.00	Total (sum of lines 1-2)	0	5,346,144		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part III | Date/Time Prepared: 5/30/2019 4:56 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	10,140,006	0	10,140,006	0.217159	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	36,553,981	0	36,553,981	0.782841	0	2.00
3.00	Total (sum of lines 1-2)	46,693,987	0	46,693,987	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,141,183	-99,666	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,434,060	1,760,831	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,575,243	1,661,165	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	201,331	1,829,907	0	3,072,755	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	48,239	0	0	4,243,130	2.00
3.00	Total (sum of lines 1-2)	0	249,570	1,829,907	0	7,315,885	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/30/2019 4:56 pm

	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)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-152,724	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-66,080	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	-9,663,398			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	-4,363,575			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	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	-3,837	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,784	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	A	-316,327	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-1,447,973	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	INSERVICE EDUCATION	B	-180	NURSING ADMINISTRATION	13.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/30/2019 4:56 pm

	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	A&G OTHER INCOME	B	-20	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	RENTAL INCOME	B	-350,359	CAP REL COSTS-BLDG & FIXT	1.00	10	33.02
33.03	MARKETING EXPENSE	A	0	SENIOR CIRCLE	194.02	0	33.03
33.04	PATIENT TELEPHONE COSTS - BENEFITS	A	-10,054	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.05	MARKETING EXPENSE	A	-310,888	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	LOBBYING EXPENSE	A	-57,506	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	PROVIDER TAX	A	-8,057,394	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	PHYSICIAN RECRUITING	A	-42,000	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	PATIENT TELEPHONE & TV DEPRECIATION	A	-6,601	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.09
33.10	SPECIAL EVENTS	A	-7,110	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	CHARITABLE CONTRIBUTIONS	A	0	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	MARKETING EXPENSE	A	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.34	LOST CHARGES	A	0	ADULTS & PEDIATRICS	30.00	0	33.34
33.35	OTHER NON-ALLOWABLE COST	A	0	ADMINISTRATIVE & GENERAL	5.00	0	33.35
33.36	DEPRECIATION ADJUSTMENT TO A&G	A	-42,000	ADMINISTRATIVE & GENERAL	5.00	0	33.36
33.37	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.37
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-24,899,810				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: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 5/30/2019 4:56 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO CAPITAL COSTS - MOVABLE E	42,944	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL HO COSTS	1,056,176	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	6,398,309	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	HO OPERATING COSTS	2,707,729	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE ALLOCATIONS	114,459	2,052,612	4.01
4.02	1.00	CAP REL COSTS-BLDG & FIXT	HO CAPITAL COSTS - BLDGS &	166,038	0	4.02
4.03	0.00			0	0	4.03
4.04	0.00			0	0	4.04
4.05	0.00			0	0	4.05
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			4,087,346	8,450,921	5.00

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

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

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

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

6.00	B	QUORUM HELATH	100.00	QHR	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: 14-0118	Period: From 01/01/2018 To 12/31/2018	Worksheet A-8-1 Date/Time Prepared: 5/30/2019 4:56 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	42,944	12		1.00
2.00	1,056,176	0		2.00
3.00	-6,398,309	0		3.00
4.00	2,707,729	0		4.00
4.01	-1,938,153	0		4.01
4.02	166,038	13		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
5.00	-4,363,575			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	HOME OFFICE		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: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 5/30/2019 4:56 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	0.00		0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	1,753,392	1,753,392	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	40.00	SUBPROVIDER - IPF	18,926	18,926	0	0	0	6.00
7.00	43.00	NURSERY	735,819	735,819	0	0	0	7.00
8.00	52.00	DELIVERY ROOM & LABOR ROOM	1,643,496	1,643,496	0	0	0	8.00
9.00	53.00	ANESTHESIOLOGY	2,904,510	2,904,510	0	0	0	9.00
10.00	54.00	RADIOLOGY-DIAGNOSTIC	684,003	684,003	0	0	0	10.00
11.00	56.00	RADIOISOTOPE	31,920	31,920	0	0	0	11.00
12.00	60.00	LABORATORY	25,200	25,200	0	0	0	12.00
13.00	69.00	ELECTROCARDIOLOGY	57,813	57,813	0	0	0	13.00
14.00	91.00	EMERGENCY	1,808,319	1,808,319	0	0	0	14.00
200.00			9,663,398	9,663,398	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	0.00		0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	6.00
7.00	43.00	NURSERY	0	0	0	0	0	7.00
8.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	8.00
9.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	9.00
10.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	10.00
11.00	56.00	RADIOISOTOPE	0	0	0	0	0	11.00
12.00	60.00	LABORATORY	0	0	0	0	0	12.00
13.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	13.00
14.00	91.00	EMERGENCY	0	0	0	0	0	14.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	0.00		0	0	0	0		1.00
2.00	0.00		0	0	0	0		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,753,392		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	40.00	SUBPROVIDER - IPF	0	0	0	18,926		6.00
7.00	43.00	NURSERY	0	0	0	735,819		7.00
8.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	1,643,496		8.00
9.00	53.00	ANESTHESIOLOGY	0	0	0	2,904,510		9.00
10.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	684,003		10.00
11.00	56.00	RADIOISOTOPE	0	0	0	31,920		11.00
12.00	60.00	LABORATORY	0	0	0	25,200		12.00
13.00	69.00	ELECTROCARDIOLOGY	0	0	0	57,813		13.00
14.00	91.00	EMERGENCY	0	0	0	1,808,319		14.00
200.00			0	0	0	9,663,398		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/30/2019 4:56 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,072,755	3,072,755				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,243,130		4,243,130			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,735,460	18,648	26,266	6,780,374		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,064,276	306,789	432,120	660,881	18,464,066	5.00
7.00	00700	OPERATION OF PLANT	5,781,556	486,814	685,691	165,333	7,119,394	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	713,340	72,821	102,570	20,309	909,040	8.00
9.00	00900	HOUSEKEEPING	1,970,799	0	0	220,348	2,191,147	9.00
10.00	01000	DIETARY	2,270,644	74,910	105,512	0	2,451,066	10.00
11.00	01100	CAFETERIA	0	68,478	96,454	0	164,932	11.00
13.00	01300	NURSING ADMINISTRATION	3,558,293	7,609	10,717	391,583	3,968,202	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,002,307	45,981	64,765	65,425	1,178,478	14.00
15.00	01500	PHARMACY	2,513,199	21,717	30,588	234,317	2,799,821	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,916,476	24,468	34,464	82,239	2,057,647	16.00
17.00	01700	SOCIAL SERVICE	1,293	0	0	173	1,466	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,235,892	446,061	628,288	1,573,645	16,883,886	30.00
31.00	03100	INTENSIVE CARE UNIT	3,184,925	82,281	115,894	260,435	3,643,535	31.00
40.00	04000	SUBPROVIDER - IPF	1,885,243	50,147	70,634	212,480	2,218,504	40.00
43.00	04300	NURSERY	1,741,462	30,582	43,076	199,130	2,014,250	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,396,805	256,585	361,406	378,116	5,392,912	50.00
51.00	05100	RECOVERY ROOM	739,020	29,438	41,465	96,245	906,168	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,646,912	48,749	68,664	267,347	3,031,672	52.00
53.00	05300	ANESTHESIOLOGY	189,012	0	0	9,490	198,502	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,498,842	92,641	130,487	241,089	2,963,059	54.00
54.01	05401	ULTRASOUND	602,531	0	0	74,846	677,377	54.01
56.00	05600	RADIOISOTOPE	669,798	15,919	22,423	37,900	746,040	56.00
57.00	05700	CT SCAN	880,885	30,848	43,450	85,742	1,040,925	57.00
58.00	05800	MRI	345,314	5,888	8,293	34,324	393,819	58.00
60.00	06000	LABORATORY	4,980,963	91,599	129,019	350,596	5,552,177	60.00
65.00	06500	RESPIRATORY THERAPY	1,176,343	22,515	31,713	131,860	1,362,431	65.00
66.00	06600	PHYSICAL THERAPY	798,614	63,247	89,086	103,123	1,054,070	66.00
67.00	06700	OCCUPATIONAL THERAPY	140,411	0	0	18,130	158,541	67.00
68.00	06800	SPEECH PATHOLOGY	277,060	0	0	36,895	313,955	68.00
69.00	06900	ELECTROCARDIOLOGY	2,764,222	285,638	402,329	283,630	3,735,819	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,701,178	0	0	0	2,701,178	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,510,268	0	0	0	4,510,268	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,033,604	0	0	0	2,033,604	73.00
74.00	07400	RENAL DIALYSIS	1,034,672	0	0	0	1,034,672	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,106,874	147,843	208,241	511,468	6,974,426	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	111,384,378	2,828,216	3,983,615	6,747,099	110,847,049	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,191	0	0	13,191	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,362	47,102	0	0	49,464	192.00
194.00	07954	OTHER NONREIMBURSABLE COSTS	9,963	0	0	0	9,963	194.00
194.01	07951	MARKETING	401,294	21,015	29,600	25,406	477,315	194.01
194.02	07953	SENIOR CIRCLE	71,668	0	0	7,869	79,537	194.02
194.03	07952	MOB	0	163,231	229,915	0	393,146	194.03
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)	111,869,665	3,072,755	4,243,130	6,780,374	111,869,665	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/30/2019 4:56 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,464,066					5.00
7.00	00700	OPERATION OF PLANT	1,407,333	8,526,727				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	179,695	274,683	1,363,418			8.00
9.00	00900	HOUSEKEEPING	433,137	0	0	2,624,284		9.00
10.00	01000	DIETARY	484,517	282,563	7,492	89,860	3,315,498	10.00
11.00	01100	CAFETERIA	32,603	258,304	0	82,145	1,488,914	11.00
13.00	01300	NURSING ADMINISTRATION	784,418	28,700	0	9,127	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	232,957	173,441	0	55,157	0	14.00
15.00	01500	PHARMACY	553,457	81,916	0	26,051	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	406,747	92,294	0	29,351	0	16.00
17.00	01700	SOCIAL SERVICE	290	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,337,559	1,682,564	337,384	535,082	1,288,372	30.00
31.00	03100	INTENSIVE CARE UNIT	720,239	310,366	83,949	98,702	95,111	31.00
40.00	04000	SUBPROVIDER - IPF	438,545	189,158	0	60,155	0	40.00
43.00	04300	NURSERY	398,169	115,357	8,705	36,685	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,066,049	967,850	230,753	307,792	566	50.00
51.00	05100	RECOVERY ROOM	179,128	111,043	36,008	35,314	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	599,289	183,884	88,441	58,478	1,003	52.00
53.00	05300	ANESTHESIOLOGY	39,239	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	585,726	349,445	124,604	111,129	0	54.00
54.01	05401	ULTRASOUND	133,901	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	147,474	60,049	14,375	19,097	0	56.00
57.00	05700	CT SCAN	205,766	116,361	0	37,005	0	57.00
58.00	05800	MRI	77,849	22,209	0	7,063	0	58.00
60.00	06000	LABORATORY	1,097,532	345,516	0	109,880	0	60.00
65.00	06500	RESPIRATORY THERAPY	269,320	84,927	11,830	27,008	0	65.00
66.00	06600	PHYSICAL THERAPY	208,364	238,573	36,677	75,870	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	31,340	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	62,061	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	738,482	1,077,442	100,730	342,644	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	533,958	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	891,572	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	401,995	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	204,530	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,378,677	557,673	272,103	177,349	46,965	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,261,918	7,604,318	1,353,051	2,330,944	2,920,931	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,608	49,756	0	15,823	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,778	177,670	10,367	56,502	336,423	192.00
194.00	07954	OTHER NONREIMBURSABLE COSTS	1,969	0	0	0	0	194.00
194.01	07951	MARKETING	94,354	79,268	0	25,208	0	194.01
194.02	07953	SENIOR CIRCLE	15,723	0	0	0	58,144	194.02
194.03	07952	MOB	77,716	615,715	0	195,807	0	194.03
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)	18,464,066	8,526,727	1,363,418	2,624,284	3,315,498	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/30/2019 4:56 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	2,026,898					11.00
13.00	01300	NURSING ADMINISTRATION	100,681	4,891,128				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	39,845	0	1,679,878			14.00
15.00	01500	PHARMACY	67,921	284,688	4,006	3,817,860		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	39,808	0	314	0	2,626,161	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	631,791	1,911,913	117,564	0	217,547	30.00
31.00	03100	INTENSIVE CARE UNIT	76,429	316,421	30,598	0	37,203	31.00
40.00	04000	SUBPROVIDER - IPF	85,201	258,001	6,207	0	25,492	40.00
43.00	04300	NURSERY	29,462	81,194	14,334	0	36,577	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	122,984	459,399	124,331	0	381,917	50.00
51.00	05100	RECOVERY ROOM	25,714	116,935	1,531	0	27,241	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	85,163	324,819	28,720	0	31,704	52.00
53.00	05300	ANESTHESIOLOGY	4,348	11,530	15,478	0	51,717	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	88,162	0	14,207	0	78,257	54.00
54.01	05401	ULTRASOUND	21,853	0	1,674	0	37,091	54.01
56.00	05600	RADIOISOTOPE	8,921	0	661	0	18,894	56.00
57.00	05700	CT SCAN	27,738	0	14,074	0	203,055	57.00
58.00	05800	MRI	8,696	0	2,074	0	32,582	58.00
60.00	06000	LABORATORY	149,785	0	100,060	0	426,508	60.00
65.00	06500	RESPIRATORY THERAPY	51,990	160,206	15,708	0	58,567	65.00
66.00	06600	PHYSICAL THERAPY	33,885	0	1,109	0	18,630	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,960	0	5	0	3,275	67.00
68.00	06800	SPEECH PATHOLOGY	12,107	0	530	0	6,514	68.00
69.00	06900	ELECTROCARDIOLOGY	109,603	344,603	27,905	0	142,705	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	339,394	0	35,650	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	685,916	0	155,834	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,817,860	152,570	73.00
74.00	07400	RENAL DIALYSIS	0	0	1,512	0	14,170	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	188,843	621,419	131,751	0	432,461	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,016,890	4,891,128	1,679,663	3,817,860	2,626,161	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	54	0	0	192.00
194.00	07954	OTHER NONREIMBURSABLE COSTS	0	0	0	0	0	194.00
194.01	07951	MARKETING	6,297	0	161	0	0	194.01
194.02	07953	SENIOR CIRCLE	3,711	0	0	0	0	194.02
194.03	07952	MOB	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,026,898	4,891,128	1,679,878	3,817,860	2,626,161	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/30/2019 4:56 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	1,756					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,224	26,944,886	0	26,944,886		30.00
31.00	03100	INTENSIVE CARE UNIT	149	5,412,702	0	5,412,702		31.00
40.00	04000	SUBPROVIDER - IPF	197	3,281,460	0	3,281,460		40.00
43.00	04300	NURSERY	186	2,734,919	0	2,734,919		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	9,054,553	0	9,054,553		50.00
51.00	05100	RECOVERY ROOM	0	1,439,082	0	1,439,082		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,433,173	0	4,433,173		52.00
53.00	05300	ANESTHESIOLOGY	0	320,814	0	320,814		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,314,589	0	4,314,589		54.00
54.01	05401	ULTRASOUND	0	871,896	0	871,896		54.01
56.00	05600	RADIOISOTOPE	0	1,015,511	0	1,015,511		56.00
57.00	05700	CT SCAN	0	1,644,924	0	1,644,924		57.00
58.00	05800	MRI	0	544,292	0	544,292		58.00
60.00	06000	LABORATORY	0	7,781,458	0	7,781,458		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,041,987	0	2,041,987		65.00
66.00	06600	PHYSICAL THERAPY	0	1,667,178	0	1,667,178		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	199,121	0	199,121		67.00
68.00	06800	SPEECH PATHOLOGY	0	395,167	0	395,167		68.00
69.00	06900	ELECTROCARDIOLOGY	0	6,619,933	0	6,619,933		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,610,180	0	3,610,180		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,243,590	0	6,243,590		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,406,029	0	6,406,029		73.00
74.00	07400	RENAL DIALYSIS	0	1,254,884	0	1,254,884		74.00
76.00	03020	ACUPUNCTURE	0	0	0	0		76.00
76.01	03610	SLEEP LAB	0	0	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	10,781,667	0	10,781,667		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,756	109,013,995	0	109,013,995		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	81,378	0	81,378		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	640,258	0	640,258		192.00
194.00	07954	OTHER NONREIMBURSABLE COSTS	0	11,932	0	11,932		194.00
194.01	07951	MARKETING	0	682,603	0	682,603		194.01
194.02	07953	SENIOR CIRCLE	0	157,115	0	157,115		194.02
194.03	07952	MOB	0	1,282,384	0	1,282,384		194.03
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,756	111,869,665	0	111,869,665		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/30/2019 4:56 pm

		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	0	18,648	26,266	44,914	44,914	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	306,789	432,120	738,909	4,376	5.00
7.00	00700	OPERATION OF PLANT	0	486,814	685,691	1,172,505	1,095	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	72,821	102,570	175,391	134	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	1,459	9.00
10.00	01000	DIETARY	0	74,910	105,512	180,422	0	10.00
11.00	01100	CAFETERIA	0	68,478	96,454	164,932	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	7,609	10,717	18,326	2,593	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	45,981	64,765	110,746	433	14.00
15.00	01500	PHARMACY	0	21,717	30,588	52,305	1,552	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	24,468	34,464	58,932	545	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	1	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	446,061	628,288	1,074,349	10,435	30.00
31.00	03100	INTENSIVE CARE UNIT	0	82,281	115,894	198,175	1,725	31.00
40.00	04000	SUBPROVIDER - IPF	0	50,147	70,634	120,781	1,407	40.00
43.00	04300	NURSERY	0	30,582	43,076	73,658	1,319	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	256,585	361,406	617,991	2,504	50.00
51.00	05100	RECOVERY ROOM	0	29,438	41,465	70,903	637	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	48,749	68,664	117,413	1,770	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	63	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	92,641	130,487	223,128	1,597	54.00
54.01	05401	ULTRASOUND	0	0	0	0	496	54.01
56.00	05600	RADIOISOTOPE	0	15,919	22,423	38,342	251	56.00
57.00	05700	CT SCAN	0	30,848	43,450	74,298	568	57.00
58.00	05800	MRI	0	5,888	8,293	14,181	227	58.00
60.00	06000	LABORATORY	0	91,599	129,019	220,618	2,322	60.00
65.00	06500	RESPIRATORY THERAPY	0	22,515	31,713	54,228	873	65.00
66.00	06600	PHYSICAL THERAPY	0	63,247	89,086	152,333	683	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	120	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	244	68.00
69.00	06900	ELECTROCARDIOLOGY	0	285,638	402,329	687,967	1,878	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	147,843	208,241	356,084	3,387	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,828,216	3,983,615	6,811,831	44,694	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,191	0	13,191	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	47,102	0	47,102	0	192.00
194.00	07954	OTHER NONREIMBURSABLE COSTS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	21,015	29,600	50,615	168	194.01
194.02	07953	SENIOR CIRCLE	0	0	0	0	52	194.02
194.03	07952	MOB	0	163,231	229,915	393,146	0	194.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	3,072,755	4,243,130	7,315,885	44,914	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/30/2019 4:56 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	743,285					5.00
7.00	00700	OPERATION OF PLANT	56,656	1,230,256				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,234	39,632	222,391			8.00
9.00	00900	HOUSEKEEPING	17,437	0	0	18,896		9.00
10.00	01000	DIETARY	19,506	40,769	1,222	647	242,566	10.00
11.00	01100	CAFETERIA	1,313	37,269	0	591	108,932	11.00
13.00	01300	NURSING ADMINISTRATION	31,579	4,141	0	66	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,378	25,025	0	397	0	14.00
15.00	01500	PHARMACY	22,281	11,819	0	188	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16,375	13,316	0	211	0	16.00
17.00	01700	SOCIAL SERVICE	12	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	134,325	242,763	55,033	3,854	94,259	30.00
31.00	03100	INTENSIVE CARE UNIT	28,995	44,780	13,693	711	6,958	31.00
40.00	04000	SUBPROVIDER - IPF	17,655	27,292	0	433	0	40.00
43.00	04300	NURSERY	16,029	16,644	1,420	264	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	42,917	139,644	37,639	2,216	41	50.00
51.00	05100	RECOVERY ROOM	7,211	16,022	5,873	254	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	24,126	26,531	14,426	421	73	52.00
53.00	05300	ANESTHESIOLOGY	1,580	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,580	50,419	20,324	800	0	54.00
54.01	05401	ULTRASOUND	5,391	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	5,937	8,664	2,345	138	0	56.00
57.00	05700	CT SCAN	8,284	16,789	0	266	0	57.00
58.00	05800	MRI	3,134	3,204	0	51	0	58.00
60.00	06000	LABORATORY	44,184	49,852	0	791	0	60.00
65.00	06500	RESPIRATORY THERAPY	10,842	12,253	1,930	194	0	65.00
66.00	06600	PHYSICAL THERAPY	8,388	34,422	5,982	546	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,262	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,498	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	29,730	155,456	16,430	2,467	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	21,496	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	35,893	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,183	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	8,234	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	55,502	80,462	44,383	1,277	3,436	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	735,147	1,097,168	220,700	16,783	213,699	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	105	7,179	0	114	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	394	25,635	1,691	407	24,613	192.00
194.00	07954	OTHER NONREIMBURSABLE COSTS	79	0	0	0	0	194.00
194.01	07951	MARKETING	3,798	11,437	0	182	0	194.01
194.02	07953	SENIOR CIRCLE	633	0	0	0	4,254	194.02
194.03	07952	MOB	3,129	88,837	0	1,410	0	194.03
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)	743,285	1,230,256	222,391	18,896	242,566	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/30/2019 4:56 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	313,037					11.00
13.00	01300	NURSING ADMINISTRATION	15,549	72,254				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,154	0	152,133			14.00
15.00	01500	PHARMACY	10,490	4,205	363	103,203		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,148	0	28	0	95,555	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	97,574	28,249	10,647	0	7,923	30.00
31.00	03100	INTENSIVE CARE UNIT	11,804	4,674	2,771	0	1,355	31.00
40.00	04000	SUBPROVIDER - IPF	13,159	3,811	562	0	928	40.00
43.00	04300	NURSERY	4,550	1,199	1,298	0	1,332	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,994	6,786	11,259	0	13,909	50.00
51.00	05100	RECOVERY ROOM	3,971	1,727	139	0	992	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,153	4,798	2,601	0	1,155	52.00
53.00	05300	ANESTHESIOLOGY	672	170	1,402	0	1,884	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,616	0	1,287	0	2,850	54.00
54.01	05401	ULTRASOUND	3,375	0	152	0	1,351	54.01
56.00	05600	RADIOISOTOPE	1,378	0	60	0	688	56.00
57.00	05700	CT SCAN	4,284	0	1,275	0	7,395	57.00
58.00	05800	MRI	1,343	0	188	0	1,187	58.00
60.00	06000	LABORATORY	23,133	0	9,061	0	15,533	60.00
65.00	06500	RESPIRATORY THERAPY	8,029	2,366	1,422	0	2,133	65.00
66.00	06600	PHYSICAL THERAPY	5,233	0	100	0	678	66.00
67.00	06700	OCCUPATIONAL THERAPY	920	0	0	0	119	67.00
68.00	06800	SPEECH PATHOLOGY	1,870	0	48	0	237	68.00
69.00	06900	ELECTROCARDIOLOGY	16,927	5,090	2,527	0	5,197	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	30,735	0	1,298	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	62,120	0	5,675	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	103,203	5,557	73.00
74.00	07400	RENAL DIALYSIS	0	0	137	0	516	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	29,165	9,179	11,931	0	15,663	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	311,491	72,254	152,113	103,203	95,555	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	5	0	0	192.00
194.00	07954	OTHER NONREIMBURSABLE COSTS	0	0	0	0	0	194.00
194.01	07951	MARKETING	973	0	15	0	0	194.01
194.02	07953	SENIOR CIRCLE	573	0	0	0	0	194.02
194.03	07952	MOB	0	0	0	0	0	194.03
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)	313,037	72,254	152,133	103,203	95,555	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/30/2019 4:56 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	13					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10	1,759,421	0	1,759,421		30.00
31.00	03100	INTENSIVE CARE UNIT	1	315,642	0	315,642		31.00
40.00	04000	SUBPROVIDER - IPF	1	186,029	0	186,029		40.00
43.00	04300	NURSERY	1	117,714	0	117,714		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	893,900	0	893,900		50.00
51.00	05100	RECOVERY ROOM	0	107,729	0	107,729		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	206,467	0	206,467		52.00
53.00	05300	ANESTHESIOLOGY	0	5,771	0	5,771		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	337,601	0	337,601		54.00
54.01	05401	ULTRASOUND	0	10,765	0	10,765		54.01
56.00	05600	RADIOISOTOPE	0	57,803	0	57,803		56.00
57.00	05700	CT SCAN	0	113,159	0	113,159		57.00
58.00	05800	MRI	0	23,515	0	23,515		58.00
60.00	06000	LABORATORY	0	365,494	0	365,494		60.00
65.00	06500	RESPIRATORY THERAPY	0	94,270	0	94,270		65.00
66.00	06600	PHYSICAL THERAPY	0	208,365	0	208,365		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,421	0	2,421		67.00
68.00	06800	SPEECH PATHOLOGY	0	4,897	0	4,897		68.00
69.00	06900	ELECTROCARDIOLOGY	0	923,669	0	923,669		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	53,529	0	53,529		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	103,688	0	103,688		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	124,943	0	124,943		73.00
74.00	07400	RENAL DIALYSIS	0	8,887	0	8,887		74.00
76.00	03020	ACUPUNCTURE	0	0	0	0		76.00
76.01	03610	SLEEP LAB	0	0	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	610,469	0	610,469		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13	6,636,148	0	6,636,148		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	20,589	0	20,589		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	99,847	0	99,847		192.00
194.00	07954	OTHER NONREIMBURSABLE COSTS	0	79	0	79		194.00
194.01	07951	MARKETING	0	67,188	0	67,188		194.01
194.02	07953	SENIOR CIRCLE	0	5,512	0	5,512		194.02
194.03	07952	MOB	0	486,522	0	486,522		194.03
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	13	7,315,885	0	7,315,885		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/30/2019 4:56 pm

		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	542,770					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		532,120				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,294	3,294	47,164,725			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	54,191	54,191	4,597,148	-18,464,066	93,405,599	5.00
7.00	00700	OPERATION OF PLANT	85,991	85,991	1,150,073	0	7,119,394	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,863	12,863	141,268	0	909,040	8.00
9.00	00900	HOUSEKEEPING	0	0	1,532,759	0	2,191,147	9.00
10.00	01000	DIETARY	13,232	13,232	0	0	2,451,066	10.00
11.00	01100	CAFETERIA	12,096	12,096	0	0	164,932	11.00
13.00	01300	NURSING ADMINISTRATION	1,344	1,344	2,723,884	0	3,968,202	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,122	8,122	455,101	0	1,178,478	14.00
15.00	01500	PHARMACY	3,836	3,836	1,629,926	0	2,799,821	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,322	4,322	572,059	0	2,057,647	16.00
17.00	01700	SOCIAL SERVICE	0	0	1,201	0	1,466	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	78,792	78,792	10,946,277	0	16,883,886	30.00
31.00	03100	INTENSIVE CARE UNIT	14,534	14,534	1,811,609	0	3,643,535	31.00
40.00	04000	SUBPROVIDER - IPF	8,858	8,858	1,478,026	0	2,218,504	40.00
43.00	04300	NURSERY	5,402	5,402	1,385,164	0	2,014,250	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,323	45,323	2,630,205	0	5,392,912	50.00
51.00	05100	RECOVERY ROOM	5,200	5,200	669,491	0	906,168	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,611	8,611	1,859,688	0	3,031,672	52.00
53.00	05300	ANESTHESIOLOGY	0	0	66,015	0	198,502	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,364	16,364	1,677,038	0	2,963,059	54.00
54.01	05401	ULTRASOUND	0	0	520,638	0	677,377	54.01
56.00	05600	RADIOISOTOPE	2,812	2,812	263,634	0	746,040	56.00
57.00	05700	CT SCAN	5,449	5,449	596,430	0	1,040,925	57.00
58.00	05800	MRI	1,040	1,040	238,758	0	393,819	58.00
60.00	06000	LABORATORY	16,180	16,180	2,438,778	0	5,552,177	60.00
65.00	06500	RESPIRATORY THERAPY	3,977	3,977	917,228	0	1,362,431	65.00
66.00	06600	PHYSICAL THERAPY	11,172	11,172	717,333	0	1,054,070	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	126,112	0	158,541	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	256,643	0	313,955	68.00
69.00	06900	ELECTROCARDIOLOGY	50,455	50,455	1,972,957	0	3,735,819	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	2,701,178	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	4,510,268	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,033,604	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	1,034,672	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	26,115	26,115	3,557,818	0	6,974,426	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	499,575	499,575	46,933,261	-18,464,066	92,382,983	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,330	0	0	0	13,191	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,320	0	0	0	49,464	192.00
194.00	07954	OTHER NONREIMBURSABLE COSTS	0	0	0	0	9,963	194.00
194.01	07951	MARKETING	3,712	3,712	176,725	0	477,315	194.01
194.02	07953	SENIOR CIRCLE	0	0	54,739	0	79,537	194.02
194.03	07952	MOB	28,833	28,833	0	0	393,146	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,072,755	4,243,130	6,780,374		18,464,066	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.661247	7.974010	0.143759		0.197676	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			44,914		743,285	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000952		0.007958	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: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/30/2019 4:56 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	399,294					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,863	910,605				8.00
9.00	00900	HOUSEKEEPING	0	0	386,431			9.00
10.00	01000	DIETARY	13,232	5,004	13,232	204,938		10.00
11.00	01100	CAFETERIA	12,096	0	12,096	92,033	54,074	11.00
13.00	01300	NURSING ADMINISTRATION	1,344	0	1,344	0	2,686	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,122	0	8,122	0	1,063	14.00
15.00	01500	PHARMACY	3,836	0	3,836	0	1,812	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,322	0	4,322	0	1,062	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	78,792	225,334	78,792	79,637	16,855	30.00
31.00	03100	INTENSIVE CARE UNIT	14,534	56,068	14,534	5,879	2,039	31.00
40.00	04000	SUBPROVIDER - IPF	8,858	0	8,858	0	2,273	40.00
43.00	04300	NURSERY	5,402	5,814	5,402	0	786	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,323	154,116	45,323	35	3,281	50.00
51.00	05100	RECOVERY ROOM	5,200	24,049	5,200	0	686	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,611	59,068	8,611	62	2,272	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	116	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,364	83,221	16,364	0	2,352	54.00
54.01	05401	ULTRASOUND	0	0	0	0	583	54.01
56.00	05600	RADIOISOTOPE	2,812	9,601	2,812	0	238	56.00
57.00	05700	CT SCAN	5,449	0	5,449	0	740	57.00
58.00	05800	MRI	1,040	0	1,040	0	232	58.00
60.00	06000	LABORATORY	16,180	0	16,180	0	3,996	60.00
65.00	06500	RESPIRATORY THERAPY	3,977	7,901	3,977	0	1,387	65.00
66.00	06600	PHYSICAL THERAPY	11,172	24,496	11,172	0	904	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	159	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	323	68.00
69.00	06900	ELECTROCARDIOLOGY	50,455	67,276	50,455	0	2,924	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	26,115	181,733	26,115	2,903	5,038	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	356,099	903,681	343,236	180,549	53,807	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,330	0	2,330	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,320	6,924	8,320	20,795	0	192.00
194.00	07954	OTHER NONREIMBURSABLE COSTS	0	0	0	0	0	194.00
194.01	07951	MARKETING	3,712	0	3,712	0	168	194.01
194.02	07953	SENIOR CIRCLE	0	0	0	3,594	99	194.02
194.03	07952	MOB	28,833	0	28,833	0	0	194.03
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)	8,526,727	1,363,418	2,624,284	3,315,498	2,026,898	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.354508	1.497266	6.791080	16.178054	37.483781	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,230,256	222,391	18,896	242,566	313,037	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.081078	0.244223	0.048899	1.183607	5.789048	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: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/30/2019 4:56 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSING WAGES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	28,003,211					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	12,496,236				14.00
15.00	01500	PHARMACY	1,629,926	29,797	2,037,441			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,338	0	810,474,267		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	33,064	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,946,277	874,529	0	67,143,994	23,037	30.00
31.00	03100	INTENSIVE CARE UNIT	1,811,609	227,611	0	11,482,538	2,804	31.00
40.00	04000	SUBPROVIDER - IPF	1,477,134	46,172	0	7,867,942	3,718	40.00
43.00	04300	NURSERY	464,863	106,628	0	11,289,338	3,505	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,630,205	924,868	0	117,875,479	0	50.00
51.00	05100	RECOVERY ROOM	669,491	11,389	0	8,407,838	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,859,688	213,639	0	9,785,164	0	52.00
53.00	05300	ANESTHESIOLOGY	66,015	115,136	0	15,962,099	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	105,682	0	24,153,393	0	54.00
54.01	05401	ULTRASOUND	0	12,449	0	11,447,905	0	54.01
56.00	05600	RADIOISOTOPE	0	4,920	0	5,831,588	0	56.00
57.00	05700	CT SCAN	0	104,693	0	62,671,301	0	57.00
58.00	05800	MRI	0	15,425	0	10,056,121	0	58.00
60.00	06000	LABORATORY	0	744,325	0	131,638,258	0	60.00
65.00	06500	RESPIRATORY THERAPY	917,228	116,847	0	18,076,121	0	65.00
66.00	06600	PHYSICAL THERAPY	0	8,248	0	5,749,982	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	37	0	1,010,888	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,940	0	2,010,567	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,972,957	207,581	0	44,044,875	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,524,668	0	11,003,078	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,102,407	0	48,096,889	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,037,441	47,089,354	0	73.00
74.00	07400	RENAL DIALYSIS	0	11,250	0	4,373,388	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,557,818	980,061	0	133,406,167	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,003,211	12,494,640	2,037,441	810,474,267	33,064	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	401	0	0	0	192.00
194.00	07954	OTHER NONREIMBURSABLE COSTS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	1,195	0	0	0	194.01
194.02	07953	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07952	MOB	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,891,128	1,679,878	3,817,860	2,626,161	1,756	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.174663	0.134431	1.873851	0.003240	0.053109	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	72,254	152,133	103,203	95,555	13	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.002580	0.012174	0.050653	0.000118	0.000393	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: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/30/2019 4:56 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,944,886		26,944,886	0	26,944,886	30.00
31.00	03100	INTENSIVE CARE UNIT	5,412,702		5,412,702	0	5,412,702	31.00
40.00	04000	SUBPROVIDER - IPF	3,281,460		3,281,460	0	3,281,460	40.00
43.00	04300	NURSERY	2,734,919		2,734,919	0	2,734,919	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,054,553		9,054,553	0	9,054,553	50.00
51.00	05100	RECOVERY ROOM	1,439,082		1,439,082	0	1,439,082	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,433,173		4,433,173	0	4,433,173	52.00
53.00	05300	ANESTHESIOLOGY	320,814		320,814	0	320,814	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,314,589		4,314,589	0	4,314,589	54.00
54.01	05401	ULTRASOUND	871,896		871,896	0	871,896	54.01
56.00	05600	RADIOISOTOPE	1,015,511		1,015,511	0	1,015,511	56.00
57.00	05700	CT SCAN	1,644,924		1,644,924	0	1,644,924	57.00
58.00	05800	MRI	544,292		544,292	0	544,292	58.00
60.00	06000	LABORATORY	7,781,458		7,781,458	0	7,781,458	60.00
65.00	06500	RESPIRATORY THERAPY	2,041,987	0	2,041,987	0	2,041,987	65.00
66.00	06600	PHYSICAL THERAPY	1,667,178	0	1,667,178	0	1,667,178	66.00
67.00	06700	OCCUPATIONAL THERAPY	199,121	0	199,121	0	199,121	67.00
68.00	06800	SPEECH PATHOLOGY	395,167	0	395,167	0	395,167	68.00
69.00	06900	ELECTROCARDIOLOGY	6,619,933		6,619,933	0	6,619,933	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,610,180		3,610,180	0	3,610,180	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,243,590		6,243,590	0	6,243,590	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,406,029		6,406,029	0	6,406,029	73.00
74.00	07400	RENAL DIALYSIS	1,254,884		1,254,884	0	1,254,884	74.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	0		0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	10,781,667		10,781,667	0	10,781,667	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,123,026		4,123,026		4,123,026	92.00
200.00		Subtotal (see instructions)	113,137,021	0	113,137,021	0	113,137,021	200.00
201.00		Less Observation Beds	4,123,026		4,123,026		4,123,026	201.00
202.00		Total (see instructions)	109,013,995	0	109,013,995	0	109,013,995	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/30/2019 4:56 pm

Title XVIII | Hospital | PPS

		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	52,437,924		52,437,924			30.00
31.00	03100	INTENSIVE CARE UNIT	11,482,538		11,482,538			31.00
40.00	04000	SUBPROVIDER - IPF	7,867,942		7,867,942			40.00
43.00	04300	NURSERY	11,289,338		11,289,338			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	56,172,480	61,702,999	117,875,479	0.076815	0.000000	50.00
51.00	05100	RECOVERY ROOM	5,406,056	3,001,782	8,407,838	0.171160	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,337,498	447,666	9,785,164	0.453050	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	7,593,339	8,368,760	15,962,099	0.020098	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,376,208	16,777,185	24,153,393	0.178633	0.000000	54.00
54.01	05401	ULTRASOUND	2,447,771	9,000,134	11,447,905	0.076162	0.000000	54.01
56.00	05600	RADIOISOTOPE	3,152,535	2,679,053	5,831,588	0.174140	0.000000	56.00
57.00	05700	CT SCAN	22,098,936	40,572,365	62,671,301	0.026247	0.000000	57.00
58.00	05800	MRI	5,312,773	4,743,348	10,056,121	0.054125	0.000000	58.00
60.00	06000	LABORATORY	68,668,841	62,969,417	131,638,258	0.059112	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	16,048,043	2,028,078	18,076,121	0.112966	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,992,551	2,757,431	5,749,982	0.289945	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	647,644	363,244	1,010,888	0.196976	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,733,177	277,390	2,010,567	0.196545	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	23,803,963	20,240,912	44,044,875	0.150300	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,939,550	4,063,528	11,003,078	0.328106	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,287,151	17,809,738	48,096,889	0.129813	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,339,307	13,750,047	47,089,354	0.136040	0.000000	73.00
74.00	07400	RENAL DIALYSIS	4,117,197	256,191	4,373,388	0.286936	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	35,713,946	97,692,221	133,406,167	0.080818	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,836,663	10,869,407	14,706,070	0.280362	0.000000	92.00
200.00		Subtotal (see instructions)	430,103,371	380,370,896	810,474,267			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	430,103,371	380,370,896	810,474,267			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/30/2019 4:56 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.076815		50.00
51.00	05100	RECOVERY ROOM	0.171160		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.453050		52.00
53.00	05300	ANESTHESIOLOGY	0.020098		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.178633		54.00
54.01	05401	ULTRASOUND	0.076162		54.01
56.00	05600	RADIOISOTOPE	0.174140		56.00
57.00	05700	CT SCAN	0.026247		57.00
58.00	05800	MRI	0.054125		58.00
60.00	06000	LABORATORY	0.059112		60.00
65.00	06500	RESPIRATORY THERAPY	0.112966		65.00
66.00	06600	PHYSICAL THERAPY	0.289945		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.196976		67.00
68.00	06800	SPEECH PATHOLOGY	0.196545		68.00
69.00	06900	ELECTROCARDIOLOGY	0.150300		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.328106		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.129813		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.136040		73.00
74.00	07400	RENAL DIALYSIS	0.286936		74.00
76.00	03020	ACUPUNCTURE	0.000000		76.00
76.01	03610	SLEEP LAB	0.000000		76.01
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.080818		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.280362		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/30/2019 4:56 pm

Title XIX | Hospital | Cost

		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	26,944,886		26,944,886	0	26,944,886	30.00
31.00	03100	INTENSIVE CARE UNIT	5,412,702		5,412,702	0	5,412,702	31.00
40.00	04000	SUBPROVIDER - IPF	3,281,460		3,281,460	0	3,281,460	40.00
43.00	04300	NURSERY	2,734,919		2,734,919	0	2,734,919	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,054,553		9,054,553	0	9,054,553	50.00
51.00	05100	RECOVERY ROOM	1,439,082		1,439,082	0	1,439,082	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,433,173		4,433,173	0	4,433,173	52.00
53.00	05300	ANESTHESIOLOGY	320,814		320,814	0	320,814	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,314,589		4,314,589	0	4,314,589	54.00
54.01	05401	ULTRASOUND	871,896		871,896	0	871,896	54.01
56.00	05600	RADIOISOTOPE	1,015,511		1,015,511	0	1,015,511	56.00
57.00	05700	CT SCAN	1,644,924		1,644,924	0	1,644,924	57.00
58.00	05800	MRI	544,292		544,292	0	544,292	58.00
60.00	06000	LABORATORY	7,781,458		7,781,458	0	7,781,458	60.00
65.00	06500	RESPIRATORY THERAPY	2,041,987	0	2,041,987	0	2,041,987	65.00
66.00	06600	PHYSICAL THERAPY	1,667,178	0	1,667,178	0	1,667,178	66.00
67.00	06700	OCCUPATIONAL THERAPY	199,121	0	199,121	0	199,121	67.00
68.00	06800	SPEECH PATHOLOGY	395,167	0	395,167	0	395,167	68.00
69.00	06900	ELECTROCARDIOLOGY	6,619,933		6,619,933	0	6,619,933	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,610,180		3,610,180	0	3,610,180	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,243,590		6,243,590	0	6,243,590	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,406,029		6,406,029	0	6,406,029	73.00
74.00	07400	RENAL DIALYSIS	1,254,884		1,254,884	0	1,254,884	74.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	0		0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	10,781,667		10,781,667	0	10,781,667	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,123,026		4,123,026		4,123,026	92.00
200.00		Subtotal (see instructions)	113,137,021	0	113,137,021	0	113,137,021	200.00
201.00		Less Observation Beds	4,123,026		4,123,026		4,123,026	201.00
202.00		Total (see instructions)	109,013,995	0	109,013,995	0	109,013,995	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/30/2019 4:56 pm

Title XIX | Hospital | Cost

		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	52,437,924		52,437,924			30.00
31.00	03100	INTENSIVE CARE UNIT	11,482,538		11,482,538			31.00
40.00	04000	SUBPROVIDER - IPF	7,867,942		7,867,942			40.00
43.00	04300	NURSERY	11,289,338		11,289,338			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	56,172,480	61,702,999	117,875,479	0.076815	0.000000	50.00
51.00	05100	RECOVERY ROOM	5,406,056	3,001,782	8,407,838	0.171160	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,337,498	447,666	9,785,164	0.453050	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	7,593,339	8,368,760	15,962,099	0.020098	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,376,208	16,777,185	24,153,393	0.178633	0.000000	54.00
54.01	05401	ULTRASOUND	2,447,771	9,000,134	11,447,905	0.076162	0.000000	54.01
56.00	05600	RADIOISOTOPE	3,152,535	2,679,053	5,831,588	0.174140	0.000000	56.00
57.00	05700	CT SCAN	22,098,936	40,572,365	62,671,301	0.026247	0.000000	57.00
58.00	05800	MRI	5,312,773	4,743,348	10,056,121	0.054125	0.000000	58.00
60.00	06000	LABORATORY	68,668,841	62,969,417	131,638,258	0.059112	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	16,048,043	2,028,078	18,076,121	0.112966	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,992,551	2,757,431	5,749,982	0.289945	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	647,644	363,244	1,010,888	0.196976	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,733,177	277,390	2,010,567	0.196545	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	23,803,963	20,240,912	44,044,875	0.150300	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,939,550	4,063,528	11,003,078	0.328106	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,287,151	17,809,738	48,096,889	0.129813	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,339,307	13,750,047	47,089,354	0.136040	0.000000	73.00
74.00	07400	RENAL DIALYSIS	4,117,197	256,191	4,373,388	0.286936	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	35,713,946	97,692,221	133,406,167	0.080818	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,836,663	10,869,407	14,706,070	0.280362	0.000000	92.00
200.00		Subtotal (see instructions)	430,103,371	380,370,896	810,474,267			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	430,103,371	380,370,896	810,474,267			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/30/2019 4:56 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03020	ACUPUNCTURE	0.000000		76.00
76.01	03610	SLEEP LAB	0.000000		76.01
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
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: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part I Date/Time Prepared: 5/30/2019 4:56 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,759,421	0	1,759,421	29,134	60.39	30.00
31.00	INTENSIVE CARE UNIT	315,642		315,642	2,804	112.57	31.00
40.00	SUBPROVIDER - IPF	186,029	0	186,029	3,718	50.03	40.00
43.00	NURSERY	117,714		117,714	1,866	63.08	43.00
200.00	Total (lines 30 through 199)	2,378,806		2,378,806	37,522		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	8,534	515,368				30.00
31.00	INTENSIVE CARE UNIT	1,068	120,225				31.00
40.00	SUBPROVIDER - IPF	2,087	104,413				40.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	11,689	740,006				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/30/2019 4:56 pm

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	893,900	117,875,479	0.007583	19,012,740	144,174	50.00
51.00	05100	RECOVERY ROOM	107,729	8,407,838	0.012813	640,804	8,211	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	206,467	9,785,164	0.021100	38,782	818	52.00
53.00	05300	ANESTHESIOLOGY	5,771	15,962,099	0.000362	2,216,010	802	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	337,601	24,153,393	0.013977	2,931,187	40,969	54.00
54.01	05401	ULTRASOUND	10,765	11,447,905	0.000940	687,836	647	54.01
56.00	05600	RADIOISOTOPE	57,803	5,831,588	0.009912	1,300,368	12,889	56.00
57.00	05700	CT SCAN	113,159	62,671,301	0.001806	7,484,515	13,517	57.00
58.00	05800	MRI	23,515	10,056,121	0.002338	1,596,299	3,732	58.00
60.00	06000	LABORATORY	365,494	131,638,258	0.002777	21,723,704	60,327	60.00
65.00	06500	RESPIRATORY THERAPY	94,270	18,076,121	0.005215	6,500,870	33,902	65.00
66.00	06600	PHYSICAL THERAPY	208,365	5,749,982	0.036238	1,165,704	42,243	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,421	1,010,888	0.002395	264,238	633	67.00
68.00	06800	SPEECH PATHOLOGY	4,897	2,010,567	0.002436	396,919	967	68.00
69.00	06900	ELECTROCARDIOLOGY	923,669	44,044,875	0.020971	8,300,677	174,073	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	53,529	11,003,078	0.004865	2,606,661	12,681	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	103,688	48,096,889	0.002156	12,465,968	26,877	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	124,943	47,089,354	0.002653	10,579,140	28,066	73.00
74.00	07400	RENAL DIALYSIS	8,887	4,373,388	0.002032	2,134,979	4,338	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	610,469	133,406,167	0.004576	11,636,522	53,249	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	269,221	14,706,070	0.018307	1,294,615	23,701	92.00
200.00		Total (lines 50 through 199)	4,526,563	727,396,525		114,978,538	686,816	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part III Date/Time Prepared: 5/30/2019 4:56 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
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	29,134	0.00	8,534	30.00
31.00	03100	INTENSIVE CARE UNIT		0	2,804	0.00	1,068	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	3,718	0.00	2,087	40.00
43.00	04300	NURSERY		0	1,866	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	37,522		11,689	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
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: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/30/2019 4:56 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
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: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/30/2019 4:56 pm

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	117,875,479	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	8,407,838	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	9,785,164	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	15,962,099	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	24,153,393	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	11,447,905	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	5,831,588	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	62,671,301	0.000000	57.00
58.00	05800	MRI	0	0	0	10,056,121	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	131,638,258	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	18,076,121	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,749,982	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,010,888	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,010,567	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	44,044,875	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	11,003,078	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	48,096,889	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	47,089,354	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,373,388	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	133,406,167	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	14,706,070	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	727,396,525		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/30/2019 4:56 pm

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		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	19,012,740	0	17,622,438	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	640,804	0	680,580	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	38,782	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	2,216,010	0	1,990,979	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,931,187	0	2,376,899	0	54.00
54.01	05401	ULTRASOUND	0.000000	687,836	0	626,373	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	1,300,368	0	786,830	0	56.00
57.00	05700	CT SCAN	0.000000	7,484,515	0	7,547,634	0	57.00
58.00	05800	MRI	0.000000	1,596,299	0	1,070,135	0	58.00
60.00	06000	LABORATORY	0.000000	21,723,704	0	8,645,279	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	6,500,870	0	407,813	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,165,704	0	92,760	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	264,238	0	25,427	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	396,919	0	28,244	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	8,300,677	0	5,826,094	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	2,606,661	0	856,757	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	12,465,968	0	7,871,674	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	10,579,140	0	2,430,860	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	2,134,979	0	129,405	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	11,636,522	0	10,965,121	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,294,615	0	2,636,705	0	92.00
200.00		Total (lines 50 through 199)		114,978,538	0	72,618,007	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/30/2019 4:56 pm

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		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	0.076815	17,622,438	0	0	1,353,668	50.00
51.00	05100	RECOVERY ROOM	0.171160	680,580	0	0	116,488	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.453050	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.020098	1,990,979	0	0	40,015	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.178633	2,376,899	0	0	424,593	54.00
54.01	05401	ULTRASOUND	0.076162	626,373	0	0	47,706	54.01
56.00	05600	RADIOISOTOPE	0.174140	786,830	0	0	137,019	56.00
57.00	05700	CT SCAN	0.026247	7,547,634	0	0	198,103	57.00
58.00	05800	MRI	0.054125	1,070,135	0	0	57,921	58.00
60.00	06000	LABORATORY	0.059112	8,645,279	0	0	511,040	60.00
65.00	06500	RESPIRATORY THERAPY	0.112966	407,813	0	0	46,069	65.00
66.00	06600	PHYSICAL THERAPY	0.289945	92,760	0	0	26,895	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.196976	25,427	0	0	5,009	67.00
68.00	06800	SPEECH PATHOLOGY	0.196545	28,244	0	0	5,551	68.00
69.00	06900	ELECTROCARDIOLOGY	0.150300	5,826,094	0	0	875,662	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.328106	856,757	0	0	281,107	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.129813	7,871,674	0	0	1,021,846	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.136040	2,430,860	56,178	0	330,694	73.00
74.00	07400	RENAL DIALYSIS	0.286936	129,405	0	0	37,131	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.080818	10,965,121	0	0	886,179	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.280362	2,636,705	0	0	739,232	92.00
200.00		Subtotal (see instructions)		72,618,007	56,178	0	7,141,928	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		72,618,007	56,178	0	7,141,928	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/30/2019 4:56 pm

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		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
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,642	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
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)	7,642	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	7,642	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0118 | Component CCN: 14-S118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/30/2019 4:56 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	893,900	117,875,479	0.007583	59,964	455	50.00
51.00	05100	RECOVERY ROOM	107,729	8,407,838	0.012813	2,370	30	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	206,467	9,785,164	0.021100	0	0	52.00
53.00	05300	ANESTHESIOLOGY	5,771	15,962,099	0.000362	6,419	2	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	337,601	24,153,393	0.013977	30,458	426	54.00
54.01	05401	ULTRASOUND	10,765	11,447,905	0.000940	14,892	14	54.01
56.00	05600	RADIOISOTOPE	57,803	5,831,588	0.009912	4,110	41	56.00
57.00	05700	CT SCAN	113,159	62,671,301	0.001806	100,467	181	57.00
58.00	05800	MRI	23,515	10,056,121	0.002338	11,630	27	58.00
60.00	06000	LABORATORY	365,494	131,638,258	0.002777	716,474	1,990	60.00
65.00	06500	RESPIRATORY THERAPY	94,270	18,076,121	0.005215	171,816	896	65.00
66.00	06600	PHYSICAL THERAPY	208,365	5,749,982	0.036238	118,188	4,283	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,421	1,010,888	0.002395	688	2	67.00
68.00	06800	SPEECH PATHOLOGY	4,897	2,010,567	0.002436	38,516	94	68.00
69.00	06900	ELECTROCARDIOLOGY	923,669	44,044,875	0.020971	43,941	921	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	53,529	11,003,078	0.004865	16,001	78	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	103,688	48,096,889	0.002156	12,137	26	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	124,943	47,089,354	0.002653	710,209	1,884	73.00
74.00	07400	RENAL DIALYSIS	8,887	4,373,388	0.002032	69,348	141	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	610,469	133,406,167	0.004576	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	14,706,070	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	4,257,342	727,396,525		2,127,628	11,491	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0118 | Component CCN: 14-S118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/30/2019 4:56 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
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: 14-0118 | Component CCN: 14-S118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/30/2019 4:56 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	117,875,479	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	8,407,838	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	9,785,164	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	15,962,099	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	24,153,393	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	11,447,905	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	5,831,588	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	62,671,301	0.000000	57.00
58.00	05800	MRI	0	0	0	10,056,121	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	131,638,258	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	18,076,121	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,749,982	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,010,888	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,010,567	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	44,044,875	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	11,003,078	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	48,096,889	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	47,089,354	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,373,388	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	133,406,167	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	14,706,070	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	727,396,525		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0118 | Component CCN: 14-S118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/30/2019 4:56 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	59,964	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	2,370	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	6,419	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	30,458	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	14,892	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	4,110	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	100,467	0	0	0	57.00
58.00	05800	MRI	0.000000	11,630	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	716,474	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	171,816	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	118,188	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	688	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	38,516	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	43,941	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	16,001	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	12,137	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	710,209	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	69,348	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		2,127,628	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/30/2019 4:56 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	29,134	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	29,134	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)	24,676	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)	8,534	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)	26,944,886	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)	26,944,886	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)	26,944,886	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)	924.86	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	7,892,755	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)	7,892,755	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/30/2019 4:56 pm

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	5,412,702	2,804	1,930.35	1,068	2,061,614	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)	12,280,384	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	22,234,753	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)	635,593	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	686,816	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,322,409	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	20,912,344	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)	4,458	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	924.86	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	4,123,026	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/30/2019 4:56 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,759,421	26,944,886	0.065297	4,123,026	269,221	90.00
91.00	Nursing School cost	0	26,944,886	0.000000	4,123,026	0	91.00
92.00	Allied health cost	0	26,944,886	0.000000	4,123,026	0	92.00
93.00	All other Medical Education	0	26,944,886	0.000000	4,123,026	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0118 Component CCN: 14-S118	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/30/2019 4:56 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,718	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,718	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)	3,718	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)	2,087	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,281,460	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,281,460	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,281,460	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)	882.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,841,965	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,841,965	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0118 | Component CCN: 14-S118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/30/2019 4:56 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	249,378	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,091,343	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)	104,413	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	11,491	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	115,904	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,975,439	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0118 | Component CCN: 14-S118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/30/2019 4:56 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	186,029	3,281,460	0.056691	0	0	90.00
91.00	Nursing School cost	0	3,281,460	0.000000	0	0	91.00
92.00	Allied health cost	0	3,281,460	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,281,460	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/30/2019 4:56 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		18,718,360		30.00
31.00	03100	INTENSIVE CARE UNIT		4,370,310		31.00
40.00	04000	SUBPROVIDER - IPF		17,388		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.076815	19,012,740	1,460,464	50.00
51.00	05100	RECOVERY ROOM	0.171160	640,804	109,680	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.453050	38,782	17,570	52.00
53.00	05300	ANESTHESIOLOGY	0.020098	2,216,010	44,537	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.178633	2,931,187	523,607	54.00
54.01	05401	ULTRASOUND	0.076162	687,836	52,387	54.01
56.00	05600	RADIOISOTOPE	0.174140	1,300,368	226,446	56.00
57.00	05700	CT SCAN	0.026247	7,484,515	196,446	57.00
58.00	05800	MRI	0.054125	1,596,299	86,400	58.00
60.00	06000	LABORATORY	0.059112	21,723,704	1,284,132	60.00
65.00	06500	RESPIRATORY THERAPY	0.112966	6,500,870	734,377	65.00
66.00	06600	PHYSICAL THERAPY	0.289945	1,165,704	337,990	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.196976	264,238	52,049	67.00
68.00	06800	SPEECH PATHOLOGY	0.196545	396,919	78,012	68.00
69.00	06900	ELECTROCARDIOLOGY	0.150300	8,300,677	1,247,592	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.328106	2,606,661	855,261	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.129813	12,465,968	1,618,245	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.136040	10,579,140	1,439,186	73.00
74.00	07400	RENAL DIALYSIS	0.286936	2,134,979	612,602	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.080818	11,636,522	940,440	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.280362	1,294,615	362,961	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		114,978,538	12,280,384	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)		114,978,538		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0118 | Component CCN: 14-S118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/30/2019 4:56 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		4,374,126		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.076815	59,964	4,606	50.00
51.00	05100	RECOVERY ROOM	0.171160	2,370	406	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.453050	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.020098	6,419	129	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.178633	30,458	5,441	54.00
54.01	05401	ULTRASOUND	0.076162	14,892	1,134	54.01
56.00	05600	RADIOISOTOPE	0.174140	4,110	716	56.00
57.00	05700	CT SCAN	0.026247	100,467	2,637	57.00
58.00	05800	MRI	0.054125	11,630	629	58.00
60.00	06000	LABORATORY	0.059112	716,474	42,352	60.00
65.00	06500	RESPIRATORY THERAPY	0.112966	171,816	19,409	65.00
66.00	06600	PHYSICAL THERAPY	0.289945	118,188	34,268	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.196976	688	136	67.00
68.00	06800	SPEECH PATHOLOGY	0.196545	38,516	7,570	68.00
69.00	06900	ELECTROCARDIOLOGY	0.150300	43,941	6,604	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.328106	16,001	5,250	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.129813	12,137	1,576	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.136040	710,209	96,617	73.00
74.00	07400	RENAL DIALYSIS	0.286936	69,348	19,898	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.080818	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.280362	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,127,628	249,378	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)		2,127,628		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0118	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/30/2019 4:56 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	14,240,714	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	4,407,947	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)	161,693	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)	287.79	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)	7.57	30.00
31.00	Percentage of Medicaid patient days (see instructions)	39.07	31.00
32.00	Sum of lines 30 and 31	46.64	32.00
33.00	Allowable disproportionate share percentage (see instructions)	27.69	33.00
34.00	Disproportionate share adjustment (see instructions)	1,290,954	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0118	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/30/2019 4:56 pm
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	6,766,695,164	8,272,872,447	35.00
35.01	Factor 3 (see instructions)	0.000286957	0.000246312	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,941,753	2,037,710	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,452,324	513,615	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,965,939		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)	22,067,247		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)	22,067,247	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,673,256	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)	23,740,503	59.00
60.00	Primary payer payments	13,643	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	23,726,860	61.00
62.00	Deductibles billed to program beneficiaries	1,883,512	62.00
63.00	Coinsurance billed to program beneficiaries	83,409	63.00
64.00	Allowable bad debts (see instructions)	900,280	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	585,182	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	829,362	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	22,345,121	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)	-30,279	70.93
70.94	HRR adjustment amount (see instructions)	-412,236	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Date/Time Prepared: 5/30/2019 4:56 pm

Title XVIII | Hospital | PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		21,902,606	71.00
71.01	Sequestration adjustment (see instructions)		438,052	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		21,077,417	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)		387,137	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		3,536,680	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)	0.9981000000	0.9981000000	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)	0.9752	0.9866	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: 14-0118	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/30/2019 4:56 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,642	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	7,141,928	2.00
3.00	OPPS payments	7,318,723	3.00
4.00	Outlier payment (see instructions)	9,875	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)	7,642	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	56,178	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)	56,178	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)	56,178	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	48,536	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	7,642	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	7,328,598	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	22,113	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,317,998	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	5,996,129	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	5,996,129	30.00
31.00	Primary payer payments	2,250	31.00
32.00	Subtotal (line 30 minus line 31)	5,993,879	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)	414,517	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	269,436	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	396,682	36.00
37.00	Subtotal (see instructions)	6,263,315	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)	6,263,315	40.00
40.01	Sequestration adjustment (see instructions)	125,266	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	5,869,931	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	268,118	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: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/30/2019 4:56 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		20,365,996		5,869,931	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		647,331		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	08/31/2018	64,090		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)		64,090		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)		21,077,417		5,869,931	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		387,137		268,118	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		21,464,554		6,138,049	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0118 | Component CCN: 14-S118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/30/2019 4:56 pm

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,909,907		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,909,907		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		52,605		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,962,512		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-0118	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/30/2019 4:56 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0118 Component CCN: 14-S118	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part II Date/Time Prepared: 5/30/2019 4:56 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	2,093,241	1.00
2.00	Net IPF PPS Outlier Payments	12,948	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	10.186301	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	2,106,189	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	2,106,189	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	2,106,189	18.00
19.00	Deductibles	141,944	19.00
20.00	Subtotal (line 18 minus line 19)	1,964,245	20.00
21.00	Coinsurance	15,356	21.00
22.00	Subtotal (line 20 minus line 21)	1,948,889	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	82,576	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	53,674	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	79,972	25.00
26.00	Subtotal (sum of lines 22 and 24)	2,002,563	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	2,002,563	31.00
31.01	Sequestration adjustment (see instructions)	40,051	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	1,909,907	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	52,605	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	12,948	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G | Date/Time Prepared: 5/30/2019 4:56 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-1,806,247	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	38,437,524	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-10,437,947	0	0	0	6.00
7.00	Inventory	3,588,473	0	0	0	7.00
8.00	Prepaid expenses	731,716	0	0	0	8.00
9.00	Other current assets	431,268	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)	30,944,787	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,610,000	0	0	0	12.00
13.00	Land improvements	2,439,950	0	0	0	13.00
14.00	Accumulated depreciation	-2,350,908	0	0	0	14.00
15.00	Buildings	23,390,308	0	0	0	15.00
16.00	Accumulated depreciation	-7,130,815	0	0	0	16.00
17.00	Leasehold improvements	6,004,154	0	0	0	17.00
18.00	Accumulated depreciation	-1,971,827	0	0	0	18.00
19.00	Fixed equipment	1,921,162	0	0	0	19.00
20.00	Accumulated depreciation	-1,149,606	0	0	0	20.00
21.00	Automobiles and trucks	19,220	0	0	0	21.00
22.00	Accumulated depreciation	-19,220	0	0	0	22.00
23.00	Major movable equipment	14,197,942	0	0	0	23.00
24.00	Accumulated depreciation	-11,219,341	0	0	0	24.00
25.00	Minor equipment depreciable	9,111,919	0	0	0	25.00
26.00	Accumulated depreciation	-7,578,875	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	28,274,063	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	5,910,399	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,910,399	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	65,129,249	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	9,179,786	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,026,293	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	1,978,913	0	0	0	43.00
44.00	Other current liabilities	1,651,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	17,835,992	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	2,748	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,748	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	17,838,740	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	47,290,509				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)	47,290,509	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	65,129,249	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 5/30/2019 4:56 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		59,921,739		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-12,631,235				2.00
3.00	Total (sum of line 1 and line 2)		47,290,504		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	ROUNDING	5		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		5		0		10.00
11.00	Subtotal (line 3 plus line 10)		47,290,509		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)		47,290,509		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/30/2019 4:56 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	55,859,320		55,859,320	1.00
2.00	SUBPROVIDER - IPF	7,867,942		7,867,942	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)	63,727,262		63,727,262	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	11,482,538		11,482,538	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)	11,482,538		11,482,538	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	75,209,800		75,209,800	17.00
18.00	Ancillary services	354,893,571	282,392,987	637,286,558	18.00
19.00	Outpatient services	0	97,977,910	97,977,910	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	430,103,371	380,370,897	810,474,268	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		136,769,475		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)		136,769,475		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-3 | Date/Time Prepared: 5/30/2019 4:56 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	810,474,268	1.00
2.00	Less contractual allowances and discounts on patients' accounts	688,759,083	2.00
3.00	Net patient revenues (line 1 minus line 2)	121,715,185	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	136,769,475	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-15,054,290	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	2,423,055	24.00
25.00	Total other income (sum of lines 6-24)	2,423,055	25.00
26.00	Total (line 5 plus line 25)	-12,631,235	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-12,631,235	29.00

CALCULATION OF CAPITAL PAYMENT | Provider CCN: 14-0118 | Period: From 01/01/2018 To 12/31/2018 | Worksheet L Parts I-III Date/Time Prepared: 5/30/2019 4:56 pm

Title XVIII | Hospital | PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,518,442	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	4,488	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)	75.88	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)	7.57	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	39.07	8.00
9.00	Sum of lines 7 and 8	46.64	9.00
10.00	Allowable disproportionate share percentage (see instructions)	9.90	10.00
11.00	Disproportionate share adjustment (see instructions)	150,326	11.00
12.00	Total prospective capital payments (see instructions)	1,673,256	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