

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: 14-0289	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/30/2019 11:39 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/30/2019 Time: 11:39 am
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> 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 ANDERSON HOSPITAL (14-0289) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) _____
Officer or Administrator of Provider(s)

Title

Date

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-60,106	41,182	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	9,412	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	1		0	9.00
200.00 Total	0	-50,694	41,183	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-MEDI CARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0289		Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part I Date/Time Prepared: 5/30/2019 11:39 am					
1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 State: IL		4.00 Zip Code: 62062-1000 County: MADISON					
1.00 Street: 6800 STATE ROUTE 162		2.00 City: MARYVILLE		3.00 State: IL		4.00 Zip Code: 62062-1000		5.00 County: MADISON			
Component Name		1.00 CCN Number	2.00 CBSA Number	3.00 Provider Type	4.00 Date Certified	5.00 Payment System (P, T, O, or N)					
		1.00	2.00	3.00	4.00	5.00	6.00 V	7.00 XVIII	8.00 XIX		
Hospital and Hospital-Based Component Identification:											
3.00	Hospital	ANDERSON HOSPITAL	140289	41180	1	11/22/1976	N	P	N		
4.00	Subprovider - IPF										
5.00	Subprovider - IRF	THE REHABILITATION CENTER	14T289	41180	5	01/01/2005	N	P	N		
6.00	Subprovider - (Other)										
7.00	Swing Beds - SNF										
8.00	Swing Beds - NF										
9.00	Hospital-Based SNF										
10.00	Hospital-Based NF										
11.00	Hospital-Based OLTC										
12.00	Hospital-Based HHA	ANDERSON HOME HEALTH	147420	41180		05/30/1985	N	P	N		
13.00	Separately Certified ASC										
14.00	Hospital-Based Hospice										
15.00	Hospital-Based Health Clinic - RHC										
16.00	Hospital-Based Health Clinic - FQHC										
17.00	Hospital-Based (CMHC) I										
18.00	Renal Dialysis										
19.00	Other										
						From:	To:				
						1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2018	12/31/2018		20.00		
21.00	Type of Control (see instructions)					2			21.00		
						1.00	2.00	3.00			
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				Y	N				22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				Y	Y				22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.				N	N				22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				N	N		N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1		N		23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	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.				1,313	1,089	0	0	2,533	208	24.00

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		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	186	128	0	0	153		25.00	
						Urban/Rural	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 OPSS 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	XVII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criteria 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)					Y		60.00	
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)						23.00	1	60.01

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

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
			1.00	2.00	3.00		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010		0.00	0.00	0.000000		66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
				1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N		
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	0	71.00
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				Y		
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)				N	0	76.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0289	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/30/2019 11:39 am		
		1.00	2.00			
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00
		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	855,151	0	1,600,000		
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N				121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y				140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0289	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/30/2019 11:39 am			
1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:			
142.00	Street:	PO Box:					
143.00	City:	State:		Zip Code:			
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?				Y	144.00	
				1.00	2.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				Y	145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N	146.00	
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.				N	147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.				N	148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				N	149.00	
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
				1.00			
165.00	Multi campus Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
				1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.				Y	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					0.00	
		Beginning		Ending			
		1.00		2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)				01/01/2018	12/31/2018	
				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	171.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0289		Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part II Date/Time Prepared: 5/30/2019 11:39 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
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				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	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.	Y					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					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	04/10/2019	Y	04/10/2019		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0289	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/30/2019 11:39 am
		Description	Y/N	Y/N
		0	1.00	3.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relieved 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.		N	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.	BKD, LLP	BKD, LLP	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(314) 231-5544	PRACHELL@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0289

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

Worksheet S-2
Part II
Date/Time Prepared:
5/30/2019 11:39 am

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BKD, LLP	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: 14-0289

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

Worksheet S-3
Part I
Date/Time Prepared:
5/30/2019 11:39 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				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	106	38,690	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)		106	38,690	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	24	8,760	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)		130	47,450	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	24	8,760		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		154				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: 14-0289

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

Worksheet S-3
Part I
Date/Time Prepared:
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Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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)	8,378	1,037	21,740			1.00
2.00 HMO and other (see instructions)	5,036	3,622				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	497	281				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)	8,378	1,037	21,740			7.00
8.00 INTENSIVE CARE UNIT	815	118	2,379			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		157	3,168			13.00
14.00 Total (see instructions)	9,193	1,312	27,287	0.00	964.22	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	2,783	186	4,121	0.00	17.96	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	3,179	0	7,901	0.00	17.49	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	999.67	27.00
28.00 Observation Bed Days		119	4,483			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	208	515			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: 14-0289

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

Worksheet S-3
Part I
Date/Time Prepared:
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Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
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	2,220	344	6,932	1.00
2.00 HMO and other (see instructions)			1,135	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	2,220	344	6,932	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	261	18	391	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0289

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

Worksheet S-3
Part II
Date/Time Prepared:
5/30/2019 11:39 am

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	54,067,926	0	54,067,926	2,079,356.35	26.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		162,469	0	162,469	1,060.24	153.24
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		2,199,766	170	2,199,936	77,877.60	28.25
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		571,354	0	571,354	12,256.00	46.62
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		412,000	0	412,000	2,104.00	195.82
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		11,473,374	0	11,473,374		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		465,407	0	465,407		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	503,998	0	503,998	14,465.93	34.84
27.00	Administrative & General	5.00	8,798,098	-409,047	8,389,051	322,917.02	25.98

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0289

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

Worksheet S-3
Part II
Date/Time Prepared:
5/30/2019 11:39 am

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)	1,321,452	0	1,321,452	31,948.75	41.36	28.00
29.00	Maintenance & Repairs	1,138,429	0	1,138,429	45,434.53	25.06	29.00
30.00	Operation of Plant	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	59,939	0	59,939	4,199.50	14.27	31.00
32.00	Housekeeping	1,219,868	0	1,219,868	79,271.15	15.39	32.00
33.00	Housekeeping under contract (see instructions)	0	0	0	0.00	0.00	33.00
34.00	Dietary	824,157	-572,227	251,930	18,573.36	13.56	34.00
35.00	Dietary under contract (see instructions)	1,364,394	0	1,364,394	16,195.00	84.25	35.00
36.00	Cafeteria	0	572,227	572,227	42,187.00	13.56	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	602,396	0	602,396	11,675.86	51.59	38.00
39.00	Central Services and Supply	753,302	0	753,302	45,103.52	16.70	39.00
40.00	Pharmacy	1,590,494	-1,590,493	1	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	922,419	0	922,419	49,548.47	18.62	41.00
42.00	Social Service	0	0	0	0.00	0.00	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0289

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

Worksheet S-3
Part III
Date/Time Prepared:
5/30/2019 11:39 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	56,591,303	0	56,591,303	2,126,439.86	26.61	1.00
2.00	Excluded area salaries (see instructions)	2,199,766	170	2,199,936	77,877.60	28.25	2.00
3.00	Subtotal salaries (line 1 minus line 2)	54,391,537	-170	54,391,367	2,048,562.26	26.55	3.00
4.00	Subtotal other wages & related costs (see inst.)	983,354	0	983,354	14,360.00	68.48	4.00
5.00	Subtotal wage-related costs (see inst.)	11,473,374	0	11,473,374	0.00	21.09	5.00
6.00	Total (sum of lines 3 thru 5)	66,848,265	-170	66,848,095	2,062,922.26	32.40	6.00
7.00	Total overhead cost (see instructions)	19,098,946	-1,999,540	17,099,406	681,520.09	25.09	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 14-0289	Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part IV Date/Time Prepared: 5/30/2019 11:39 am
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	1,453,938	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	16,815	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)	5,859,488	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	171,540	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	42,363	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)	68,483	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	13,713	14.00
15.00	'Workers' Compensation Insurance	85,180	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	3,940,270	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	76,308	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	65,059	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	145,624	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	11,938,781	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0289

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

Worksheet S-3
Part V
Date/Time Prepared:
5/30/2019 11:39 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	571,354	11,938,781	1.00
2.00	Hospital	571,354	11,938,781	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 14-0289 Component CCN: 14-7420		Period: From 01/01/2018 To 12/31/2018		Worksheet S-4 Date/Time Prepared: 5/30/2019 11:39 am		
				Home Health Agency I		PPS		
							1.00	
0.00	County							0.00
		Title V	Title XVIII	Title XIX	Other	Total		
		1.00	2.00	3.00	4.00	5.00		
HOME HEALTH AGENCY STATISTICAL DATA								
1.00	Home Health Aide Hours	0	1,690	248	1,598	3,536	1.00	
2.00	Unduplicated Census Count (see instructions)	0.00	234.00	38.00	343.00	615.00	2.00	
		Number of Employees (Full Time Equivalent)						
		Enter the number of hours in your normal work week			Staff	Contract	Total	
		0			1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES								
3.00	Administrator and Assistant Administrator(s)	0.00		0.00	0.00	0.00	3.00	
4.00	Director(s) and Assistant Director(s)			1.00	0.00	1.00	4.00	
5.00	Other Administrative Personnel			2.80	0.00	2.80	5.00	
6.00	Direct Nursing Service			3.20	0.00	3.20	6.00	
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00	
8.00	Physical Therapy Service			4.00	0.00	4.00	8.00	
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00	
10.00	Occupational Therapy Service			1.40	0.00	1.40	10.00	
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00	
12.00	Speech Pathology Service			2.00	0.00	2.00	12.00	
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00	
14.00	Medical Social Service			1.00	0.00	1.00	14.00	
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00	
16.00	Home Health Aide			1.70	0.00	1.70	16.00	
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00	
18.00	MANAGER			1.00	0.00	1.00	18.00	
HOME HEALTH AGENCY CBSA CODES								
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00	
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			41180			20.00	
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)		
		Without Outliers	With Outliers					
		1.00	2.00	3.00	4.00	5.00		
PPS ACTIVITY DATA								
21.00	Skilled Nursing Visits	1,078	48	135	32	1,293	21.00	
22.00	Skilled Nursing Visit Charges	178,708	7,968	22,362	5,280	214,318	22.00	
23.00	Physical Therapy Visits	1,093	2	18	30	1,143	23.00	
24.00	Physical Therapy Visit Charges	181,206	332	2,988	4,948	189,474	24.00	
25.00	Occupational Therapy Visits	403	1	6	11	421	25.00	
26.00	Occupational Therapy Visit Charges	66,786	166	996	1,818	69,766	26.00	
27.00	Speech Pathology Visits	100	0	0	4	104	27.00	
28.00	Speech Pathology Visit Charges	16,576	0	0	664	17,240	28.00	
29.00	Medical Social Service Visits	0	0	0	0	0	29.00	
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00	
31.00	Home Health Aide Visits	212	4	1	1	218	31.00	
32.00	Home Health Aide Visit Charges	18,652	353	88	88	19,181	32.00	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,886	55	160	78	3,179	33.00	
34.00	Other Charges	0	0	0	0	0	34.00	
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	461,928	8,819	26,434	12,798	509,979	35.00	
36.00	Total Number of Episodes (standard/non outlier)	215		57	7	279	36.00	
37.00	Total Number of Outlier Episodes		2		1	3	37.00	
38.00	Total Non-Routine Medical Supply Charges	7,278	1,625	1,267	615	10,785	38.00	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0289	Period: From 01/01/2018 To 12/31/2018	Worksheet S-10 Date/Time Prepared: 5/30/2019 11:39 am
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			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)		0.212763	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		11,444,221	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		2,001,076	5.00	
6.00	Medicaid charges		82,343,394	6.00	
7.00	Medicaid cost (line 1 times line 6)		17,519,628	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)		4,074,331	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)		4,074,331	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)	5,783,932	4,044,054	9,827,986	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,230,607	4,044,054	5,274,661	21.00
22.00	Payments received from patients for amounts previously written off as charity care	28,678	0	28,678	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,201,929	4,044,054	5,245,983	23.00
			1.00		
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		8,148,107		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		481,462		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		740,711		27.01
28.00	Non-Medicare bad debt expense (see instructions)		7,407,396		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		1,835,269		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		7,081,252		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		11,155,583		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 14-0289		Period: From 01/01/2018 To 12/31/2018		Worksheet A	
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassified (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		3,234,747	3,234,747	1,423,658	4,658,405	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,383,974	3,383,974	352,937	3,736,911	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	503,998	12,412,169	12,916,167	1,990	12,918,157	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,798,098	24,793,115	33,591,213	-1,159,292	32,431,921	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,138,429	839,431	1,977,860	-4	1,977,856	6.00
7.00	00700	OPERATION OF PLANT	0	2,166,572	2,166,572	57,331	2,223,903	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	59,939	490,684	550,623	0	550,623	8.00
9.00	00900	HOUSEKEEPING	1,219,868	291,096	1,510,964	-9,674	1,501,290	9.00
10.00	01000	DIETARY	824,157	994,544	1,818,701	-1,262,756	555,945	10.00
11.00	01100	CAFETERIA	0	0	0	1,262,756	1,262,756	11.00
13.00	01300	NURSING ADMINISTRATION	602,396	303,143	905,539	-295,199	610,340	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	753,302	504,724	1,258,026	-424,894	833,132	14.00
15.00	01500	PHARMACY	1,590,494	5,855,892	7,446,386	-1,686,905	5,759,481	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	922,419	442,355	1,364,774	0	1,364,774	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	163,177	-7,203	155,974	0	155,974	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,980,074	656,598	7,636,672	2,694,453	10,331,125	30.00
31.00	03100	INTENSIVE CARE UNIT	2,105,600	200,286	2,305,886	-12,821	2,293,065	31.00
41.00	04100	SUBPROVIDER - I RF	1,015,225	746,914	1,762,139	-1,124	1,761,015	41.00
43.00	04300	NURSERY	0	0	0	547,592	547,592	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,008,203	9,079,847	14,088,050	-6,956,390	7,131,660	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,294,096	483,631	4,777,727	-3,493,666	1,284,061	52.00
53.00	05300	ANESTHESIOLOGY	0	337,609	337,609	-67,245	270,364	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,213,251	1,110,817	3,324,068	85,539	3,409,607	54.00
56.00	05600	RADIOISOTOPE	163,171	380,380	543,551	-294,632	248,919	56.00
57.00	05700	CT SCAN	409,769	874,721	1,284,490	-241,262	1,043,228	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	163,393	433,528	596,921	-53,737	543,184	58.00
59.00	05900	CARDIAC CATHETERIZATION	764,122	2,005,700	2,769,822	-1,546,119	1,223,703	59.00
60.00	06000	LABORATORY	1,604,672	3,395,497	5,000,169	-34,949	4,965,220	60.00
65.00	06500	RESPIRATORY THERAPY	1,127,709	424,980	1,552,689	-201,808	1,350,881	65.00
66.00	06600	PHYSICAL THERAPY	1,520,219	268,971	1,789,190	-12,755	1,776,435	66.00
67.00	06700	OCCUPATIONAL THERAPY	873,015	22,757	895,772	133,764	1,029,536	67.00
68.00	06800	SPEECH PATHOLOGY	720,681	30,680	751,361	80,872	832,233	68.00
68.01	03040	AUDIOLOGY	170,888	199,868	370,756	-169,031	201,725	68.01
69.00	06900	ELECTROCARDIOLOGY	496,855	153,610	650,465	-9,849	640,616	69.00
69.01	03160	CARDIOPULMONARY	537,474	113,509	650,983	-74,709	576,274	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	50,532	9,332	59,864	-6,739	53,125	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	10,964,451	10,964,451	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,586,089	1,586,089	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	295,199	295,199	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	765,720	7,593,359	8,359,079	-105,322	8,253,757	90.00
91.00	09100	EMERGENCY	5,485,616	808,535	6,294,151	-346,946	5,947,205	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	1,021,364	95,455	1,116,819	-8,452	1,108,367	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		1,010,351	1,010,351	-1,010,351	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	54,067,926	86,142,178	140,210,104	0	140,210,104	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	54,067,926	86,142,178	140,210,104	0	140,210,104	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0289

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

Worksheet A
Date/Time Prepared:
5/30/2019 11:39 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-738,678	3,919,727	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-271,673	3,465,238	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-58,421	12,859,736	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-12,095,300	20,336,621	5.00
6.00	00600	MAINTENANCE & REPAIRS	-22,577	1,955,279	6.00
7.00	00700	OPERATION OF PLANT	-23,774	2,200,129	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	550,623	8.00
9.00	00900	HOUSEKEEPING	0	1,501,290	9.00
10.00	01000	DIETARY	0	555,945	10.00
11.00	01100	CAFETERIA	0	1,262,756	11.00
13.00	01300	NURSING ADMINISTRATION	-25,611	584,729	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	833,132	14.00
15.00	01500	PHARMACY	0	5,759,481	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-127,407	1,237,367	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	0	155,974	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	10,331,125	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,293,065	31.00
41.00	04100	SUBPROVIDER - I RF	0	1,761,015	41.00
43.00	04300	NURSERY	0	547,592	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	7,131,660	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-220	1,283,841	52.00
53.00	05300	ANESTHESIOLOGY	-72,795	197,569	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-64,312	3,345,295	54.00
56.00	05600	RADIOISOTOPE	0	248,919	56.00
57.00	05700	CT SCAN	0	1,043,228	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	543,184	58.00
59.00	05900	CARDIAC CATHETERIZATION	-10,192	1,213,511	59.00
60.00	06000	LABORATORY	0	4,965,220	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,350,881	65.00
66.00	06600	PHYSICAL THERAPY	0	1,776,435	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,029,536	67.00
68.00	06800	SPEECH PATHOLOGY	0	832,233	68.00
68.01	03040	AUDIOLOGY	-133,804	67,921	68.01
69.00	06900	ELECTROCARDIOLOGY	0	640,616	69.00
69.01	03160	CARDIOPULMONARY	-22,498	553,776	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	53,125	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,964,451	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,586,089	73.00
74.00	07400	RENAL DIALYSIS	0	295,199	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	8,253,757	90.00
91.00	09100	EMERGENCY	-13,900	5,933,305	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	1,108,367	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-13,681,162	126,528,942	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-13,681,162	126,528,942	200.00

RECLASSIFICATIONS

Provider CCN: 14-0289

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

Worksheet A-6
Date/Time Prepared:
5/30/2019 11:39 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - TO RECLASS INTEREST EXPENSE TO CAPTL					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	738,678	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	271,673	2.00
	0		0	1,010,351	
B - TO RECLASS EXPENSES FOR CAFETERIA					
1.00	CAFETERIA	11.00	572,227	690,529	1.00
	0		572,227	690,529	
C - TO RECLASS SAL EXP FROM LDR					
1.00	ADULTS & PEDIATRICS	30.00	2,566,938	289,106	1.00
2.00	NURSERY	43.00	516,344	58,154	2.00
	0		3,083,282	347,260	
E - TO RECLASS ELECTRICITY EXP					
1.00	OPERATION OF PLANT	7.00	0	77,467	1.00
2.00	0	0.00	0	0	2.00
	0		0	77,467	
F - TO RECLASS TELEPHONE EXP					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,578	1.00
2.00	0	0.00	0	0	2.00
3.00	0	0.00	0	0	3.00
	0		0	2,578	
G - TO RECLASS RENAL DIALYSIS EXP					
1.00	RENAL DIALYSIS	74.00	0	295,199	1.00
	0		0	295,199	
H - INSURANCE EXPENSE					
1.00	OTHER CAP REL COSTS	3.00	0	132,316	1.00
	0		0	132,316	
J - TO RECLASS MED SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	10,964,451	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
	0		0	10,964,451	
K - TO RECLASS REAL ESTATE TAXES					
1.00	OTHER CAP REL COSTS	3.00	0	174,154	1.00
	0		0	174,154	
L - TO RECLASS PHYSICIAN OFFICE LEASE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	459,774	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	459,774	
M - TO RECLASS PROF RENUMERATION					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	200,000	1.00
2.00	ANESTHESIOLOGY	53.00	0	175,000	2.00
	0		0	375,000	
N - TO RECLASS PENSION AUDIT COSTS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,018	1.00
	0		0	2,018	

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
O - TO RECLASS REHAB ADMIN EXP					
1.00	SPEECH PATHOLOGY	68.00	74,714	6,158	1.00
2.00	AUDIOLOGY	68.01	18,525	1,527	2.00
3.00	OCCUPATIONAL THERAPY	67.00	123,639	10,191	3.00
4.00	PHYSICAL THERAPY	66.00	192,169	15,839	4.00
	O		409,047	33,715	
P - TO RECLASS PHARMACISTS SALARIES					
1.00	ADULTS & PEDIATRICS	30.00	3,256	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	403	0	2.00
3.00	SUBPROVIDER - IRF	41.00	170	0	3.00
4.00	NURSERY	43.00	25	0	4.00
5.00	OPERATING ROOM	50.00	233	0	5.00
6.00	DELIVERY ROOM & LABOR ROOM	52.00	58	0	6.00
7.00	CARDIAC CATHETERIZATION	59.00	94	0	7.00
8.00	DRUGS CHARGED TO PATIENTS	73.00	1,586,089	0	8.00
9.00	EMERGENCY	91.00	165	0	9.00
	O		1,590,493	0	
Q - TO RECLASS CABLE TB EXPS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	23,774	1.00
2.00		0.00	0	0	2.00
	O		0	23,774	
500.00	Grand Total: Increases		5,655,049	14,588,586	500.00

RECLASSIFICATIONS

Provider CCN: 14-0289

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

Worksheet A-6
Date/Time Prepared:
5/30/2019 11:39 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - TO RECLASS INTEREST EXPENSE TO CAPTL							
1.00	INTEREST EXPENSE	113.00	0	1,010,351	11		1.00
2.00		0.00	0	0	11		2.00
	0		0	1,010,351			
B - TO RECLASS EXPENSES FOR CAFETERIA							
1.00	DIETARY	10.00	572,227	690,529	0		1.00
	0		572,227	690,529			
C - TO RECLASS SAL EXP FROM LDR							
1.00	DELIVERY ROOM & LABOR ROOM	52.00	3,083,282	347,260	0		1.00
2.00		0.00	0	0	0		2.00
	0		3,083,282	347,260			
E - TO RECLASS ELECTRICITY EXP							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,012	0		1.00
2.00	CLINIC	90.00	0	76,455	0		2.00
	0		0	77,467			
F - TO RECLASS TELEPHONE EXP							
1.00	CLINIC	90.00	0	1,048	0		1.00
2.00	EMERGENCY	91.00	0	100	0		2.00
3.00	HOME HEALTH AGENCY	101.00	0	1,430	0		3.00
	0		0	2,578			
G - TO RECLASS RENAL DIALYSIS EXP							
1.00	NURSING ADMINISTRATION	13.00	0	295,199	0		1.00
	0		0	295,199			
H - INSURANCE EXPENSE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	132,316	12		1.00
	0		0	132,316			
J - TO RECLASS MED SUPPLIES							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	28	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,017	0		2.00
3.00	MAINTENANCE & REPAIRS	6.00	0	4	0		3.00
4.00	HOUSEKEEPING	9.00	0	9,674	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	424,894	0		5.00
6.00	PHARMACY	15.00	0	96,412	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	164,847	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	13,224	0		8.00
9.00	SUBPROVIDER - IRF	41.00	0	1,294	0		9.00
10.00	NURSERY	43.00	0	26,931	0		10.00
11.00	OPERATING ROOM	50.00	0	6,956,623	0		11.00
12.00	DELIVERY ROOM & LABOR ROOM	52.00	0	63,182	0		12.00
13.00	ANESTHESIOLOGY	53.00	0	242,245	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	114,461	0		14.00
15.00	RADIOISOTOPE	56.00	0	294,632	0		15.00
16.00	CT SCAN	57.00	0	241,262	0		16.00
17.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	53,737	0		17.00
18.00	CARDIAC CATHETERIZATION	59.00	0	1,546,213	0		18.00
19.00	LABORATORY	60.00	0	34,949	0		19.00
20.00	RESPIRATORY THERAPY	65.00	0	201,808	0		20.00
21.00	PHYSICAL THERAPY	66.00	0	1,466	0		21.00
22.00	OCCUPATIONAL THERAPY	67.00	0	66	0		22.00
23.00	AUDIOLOGY	68.01	0	189,083	0		23.00
24.00	ELECTROCARDIOLOGY	69.00	0	9,849	0		24.00
25.00	CARDIOPULMONARY	69.01	0	74,709	0		25.00
26.00	ELECTROENCEPHALOGRAPHY	70.00	0	6,739	0		26.00
27.00	CLINIC	90.00	0	24,181	0		27.00
28.00	EMERGENCY	91.00	0	163,899	0		28.00
29.00	HOME HEALTH AGENCY	101.00	0	7,022	0		29.00
	0		0	10,964,451			
K - TO RECLASS REAL ESTATE TAXES							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	174,154	0		1.00
	0		0	174,154			
L - TO RECLASS PHYSICIAN OFFICE LEASE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	57,365	10		1.00
2.00	PHYSICAL THERAPY	66.00	0	219,297	10		2.00
3.00	EMERGENCY	91.00	0	183,112	10		3.00
	0		0	459,774			
M - TO RECLASS PROF RENUMERATION							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	375,000	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	375,000			
N - TO RECLASS PENSION AUDIT COSTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,018	0		1.00
	0		0	2,018			

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
O - TO RECLASS REHAB ADMIN EXP						
1.00	ADMINISTRATIVE & GENERAL	5.00	409,047	33,715	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
O			409,047	33,715		
P - TO RECLASS PHARMACISTS SALARIES						
1.00	PHARMACY	15.00	1,590,493	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
O			1,590,493	0		
Q - TO RECLASS CABLE TB EXPS						
1.00	CLINIC	90.00	0	3,638	0	1.00
2.00	OPERATION OF PLANT	7.00	0	20,136	0	2.00
O			0	23,774		
500.00	Grand Total: Decreases		5,655,049	14,588,586		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0289

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

Worksheet A-7
Part I
Date/Time Prepared:
5/30/2019 11:39 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	963,454	0	0	0	0	1.00
2.00	Land Improvements	3,118,215	32,933	0	32,933	0	2.00
3.00	Buildings and Fixtures	108,732,933	5,597,832	0	5,597,832	0	3.00
4.00	Building Improvements	24,000	0	0	0	0	4.00
5.00	Fixed Equipment	5,371,373	208,427	0	208,427	0	5.00
6.00	Movable Equipment	40,874,802	1,549,293	0	1,549,293	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	159,084,777	7,388,485	0	7,388,485	0	8.00
9.00	Reconciling Items	434,286	6,044,235	0	6,044,235	0	9.00
10.00	Total (line 8 minus line 9)	158,650,491	1,344,250	0	1,344,250	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	963,454	0				1.00
2.00	Land Improvements	3,151,148	0				2.00
3.00	Buildings and Fixtures	114,330,765	0				3.00
4.00	Building Improvements	24,000	0				4.00
5.00	Fixed Equipment	5,579,800	0				5.00
6.00	Movable Equipment	42,424,095	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	166,473,262	0				8.00
9.00	Reconciling Items	6,478,521	0				9.00
10.00	Total (line 8 minus line 9)	159,994,741	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0289

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

Worksheet A-7
Part II
Date/Time Prepared:
5/30/2019 11:39 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	3,234,747	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,318,030	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	6,552,777	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	3,234,747				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	65,944	3,383,974				2.00
3.00	Total (sum of lines 1-2)	65,944	6,618,721				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0289

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

Worksheet A-7
Part III
Date/Time Prepared:
5/30/2019 11:39 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	117,570,646	0	117,570,646	0.734841	97,231	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	42,424,095	0	42,424,095	0.265159	35,085	2.00
3.00	Total (sum of lines 1-2)	159,994,741	0	159,994,741	1.000000	132,316	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	127,975	0	225,206	3,234,747	459,774	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	46,179	0	81,264	3,318,030	0	2.00
3.00	Total (sum of lines 1-2)	174,154	0	306,470	6,552,777	459,774	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	97,231	127,975	0	3,919,727	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	35,085	46,179	65,944	3,465,238	2.00
3.00	Total (sum of lines 1-2)	0	132,316	174,154	65,944	7,384,965	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0289

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

Worksheet A-8

Date/Time Prepared:
5/30/2019 11:39 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-738,678	CAP REL COSTS-BLDG & FIXT		1.00	11 1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-271,673	CAP REL COSTS-MVBLE EQUIP		2.00	11 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	ADMINISTRATIVE & GENERAL		5.00	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	-16,635	ADMINISTRATIVE & GENERAL		5.00	0 7.00
8.00 Television and radio service (chapter 21)	A	-23,774	OPERATION OF PLANT		7.00	0 8.00
9.00 Parking lot (chapter 21)		0			0.00	0 9.00
10.00 Provider-based physician adjustment	A-8-2	-3,623,016				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	-162,469				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	B	-103,486	MEDICAL RECORDS & LIBRARY		16.00	0 16.00
17.00 Sale of drugs to other than patients		0			0.00	0 17.00
18.00 Sale of medical records and abstracts		0			0.00	0 18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0			0.00	0 19.00
20.00 Vending machines		0			0.00	0 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	0 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	0 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY		65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY		66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***		114.00	25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT		1.00	0 26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP		2.00	0 27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***		19.00	28.00
29.00 Physicians' assistant		0			0.00	0 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY		67.00	30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS		30.00	30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY		68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0 32.00
33.00 OTHER MISC INCOME	B	-706,187	ADMINISTRATIVE & GENERAL		5.00	0 33.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
33.01 OTHER REVENUE CR CARD SHARING REV	B	-49,022	ADMINISTRATIVE & GENERAL	5.00	0 33.01
33.02 MANAGEMENT FEES	B	-180,000	ADMINISTRATIVE & GENERAL	5.00	0 33.02
33.03 EDUCATION CLASSES - VARIOUS	B	-3,408	ADMINISTRATIVE & GENERAL	5.00	0 33.03
33.04 OB LACTATION REVENUE	B	-220	DELIVERY ROOM & LABOR ROOM	52.00	0 33.04
33.05 AH OTHER REVENUE HEALTH MGM	B	-22,498	CARDIOPULMONARY	69.01	0 33.05
33.06 FINANCIAL SERVICE DONATION HMAP	A	-7,077	ADMINISTRATIVE & GENERAL	5.00	0 33.06
33.07 SALES TAX REVERSAL	A	27	ADMINISTRATIVE & GENERAL	5.00	0 33.07
33.08 PHYSICIAN RECRUITMENT	A	-258,568	ADMINISTRATIVE & GENERAL	5.00	0 33.08
33.09 LOBBYING PORTION OF DUES	A	-37,108	ADMINISTRATIVE & GENERAL	5.00	0 33.09
33.10 ALCOHOL EXPENSE	A	-6,200	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.10
33.11 ALCOHOL EXPENSE	A	-1,511	MEDICAL RECORDS & LIBRARY	16.00	0 33.11
33.12 ENTERTAINMENT EXPENSE	A	-22,410	MEDICAL RECORDS & LIBRARY	16.00	0 33.12
33.13 PROMOTIONAL ITEMS	A	-26,094	ADMINISTRATIVE & GENERAL	5.00	0 33.13
33.14 PUBLICITY SALARIES	A	-77,251	ADMINISTRATIVE & GENERAL	5.00	0 33.14
33.15 PUBLICITY EXPENSES	A	-318,886	ADMINISTRATIVE & GENERAL	5.00	0 33.15
33.16 PUBLICITY BENEFITS	A	-17,888	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.16
33.17 DONATION EXPENSE	A	-4,050	ADMINISTRATIVE & GENERAL	5.00	0 33.17
33.18 PROVIDER TAX OFFSET	A	-6,729,575	ADMINISTRATIVE & GENERAL	5.00	0 33.18
33.20 ADVERTISING EXPENSE	A	-34,333	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.20
33.21 SI SHA CONTRACT SERVICES	B	-133,804	AUDIOLOGY	68.01	0 33.21
33.22 INCORPORATION COSTS-SURGERY CENTER	A	-105,368	ADMINISTRATIVE & GENERAL	5.00	0 33.22
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-13,681,162			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: 14-0289

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

Worksheet A-8-1

Date/Time Prepared:
5/30/2019 11:39 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	0	114,281	1.00
2.00	6.00	MAINTENANCE & REPAIRS	0	22,577	2.00
3.00	13.00	NURSING ADMINISTRATION	0	25,611	3.00
4.00	0.00		0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.		0	162,469	5.00

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

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			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	C		0.00	SW IL HLTH FAC	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: 14-0289

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

Worksheet A-8-1

Date/Time Prepared:
5/30/2019 11:39 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-114,281	0		1.00
2.00	-22,577	0		2.00
3.00	-25,611	0		3.00
4.00	0	0		4.00
5.00	-162,469			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			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: 14-0289

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

Worksheet A-8-2

Date/Time Prepared:
5/30/2019 11:39 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	3,467,206	3,455,206	12,000	211,500	53	1.00
2.00	53.00	ANESTHESIOLOGY	175,000	0	175,000	239,400	888	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	200,000	0	200,000	271,900	1,038	3.00
4.00	59.00	CARDIAC CATHETERIZATION	25,000	0	25,000	246,400	125	4.00
5.00	91.00	EMERGENCY	13,900	13,900	0	211,500	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,881,106	3,469,106	412,000		2,104	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	5,389	269	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	102,205	5,110	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	135,688	6,784	0	0	0	3.00
4.00	59.00	CARDIAC CATHETERIZATION	14,808	740	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			258,090	12,903	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	5,389	6,611	3,461,817	1.00
2.00	53.00	ANESTHESIOLOGY	0	102,205	72,795	72,795	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	135,688	64,312	64,312	3.00
4.00	59.00	CARDIAC CATHETERIZATION	0	14,808	10,192	10,192	4.00
5.00	91.00	EMERGENCY	0	0	0	13,900	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	258,090	153,910	3,623,016	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0289

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

Worksheet B Part I Date/Time Prepared: 5/30/2019 11:39 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	3,919,727	3,919,727			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	3,465,238		3,465,238		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	12,859,736	12,146	26,157	12,898,039	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	20,336,621	596,755	961,038	2,004,349	5.00
6.00 00600	MAINTENANCE & REPAIRS	1,955,279	153,593	406,685	274,526	6.00
7.00 00700	OPERATION OF PLANT	2,200,129	174,819	0	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	550,623	2,073	0	14,454	8.00
9.00 00900	HOUSEKEEPING	1,501,290	28,885	5,824	294,165	9.00
10.00 01000	DIETARY	555,945	103,599	3,584	60,752	10.00
11.00 01100	CAFETERIA	1,262,756	0	8,139	137,990	11.00
13.00 01300	NURSING ADMINISTRATION	584,729	14,121	0	145,265	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	833,132	100,144	58,693	181,655	14.00
15.00 01500	PHARMACY	5,759,481	23,902	108,090	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,237,367	64,008	1,874	222,437	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
23.00 02300	PARAMEDICAL EDUCATION PRGM	155,974	0	0	39,349	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	10,331,125	408,449	152,300	2,302,993	30.00
31.00 03100	INTENSIVE CARE UNIT	2,293,065	85,896	51,232	507,852	31.00
41.00 04100	SUBPROVIDER - IRF	1,761,015	66,811	872	244,857	41.00
43.00 04300	NURSERY	547,592	4,944	14,114	124,520	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	7,131,660	300,228	243,443	1,207,759	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,283,841	299,975	33,111	291,996	52.00
53.00 05300	ANESTHESIOLOGY	197,569	0	10,633	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,345,295	27,270	232,749	533,714	54.00
56.00 05600	RADIOISOTOPE	248,919	7,241	9,334	39,348	56.00
57.00 05700	CT SCAN	1,043,228	97,497	234,125	98,814	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	543,184	20,253	26,668	39,401	58.00
59.00 05900	CARDIAC CATHETERIZATION	1,213,511	22,472	219,237	184,287	59.00
60.00 06000	LABORATORY	4,965,220	72,329	237,524	386,959	60.00
65.00 06500	RESPIRATORY THERAPY	1,350,881	43,795	59,617	271,941	65.00
66.00 06600	PHYSICAL THERAPY	1,776,435	77,867	11,866	412,934	66.00
67.00 06700	OCCUPATIONAL THERAPY	1,029,536	140,523	2,789	240,338	67.00
68.00 06800	SPEECH PATHOLOGY	832,233	54,938	773	191,806	68.00
68.01 03040	AUDIOLOGY	67,921	2,229	3,914	45,676	68.01
69.00 06900	ELECTROCARDIOLOGY	640,616	0	59,068	119,814	69.00
69.01 03160	CARDIOPULMONARY	553,776	44,651	19,165	129,609	69.01
70.00 07000	ELECTROENCEPHALOGRAPHY	53,125	0	5,404	12,186	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,964,451	0	0	0	71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,586,089	0	0	382,477	73.00
74.00 07400	RENAL DIALYSIS	295,199	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	8,253,757	52,359	180,472	184,650	90.00
91.00 09100	EMERGENCY	5,933,305	208,152	76,744	1,322,869	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	1,108,367	8,944	0	246,297	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	126,528,942	3,320,868	3,465,238	12,898,039	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,277	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	441,081	0	0	192.00
193.00 19300	NONPAID WORKERS	0	147,501	0	0	193.00
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	126,528,942	3,919,727	3,465,238	12,898,039	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0289

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

Worksheet B Part I Date/Time Prepared: 5/30/2019 11:39 am

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	23,898,763				5.00
6.00	00600	MAINTENANCE & REPAIRS	649,707	3,439,790			6.00
7.00	00700	OPERATION OF PLANT	553,038	190,464	3,118,450		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	132,068	2,258	2,168	703,644	8.00
9.00	00900	HOUSEKEEPING	426,177	31,470	30,203	0	2,318,014
10.00	01000	DIETARY	168,565	112,871	108,324	0	0
11.00	01100	CAFETERIA	328,077	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	173,277	15,385	14,765	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	273,294	109,106	104,712	12,537	16,692
15.00	01500	PHARMACY	1,371,906	26,041	24,992	0	25,446
16.00	01600	MEDICAL RECORDS & LIBRARY	355,276	69,737	66,928	0	22,799
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
23.00	02300	PARAMEDICAL EDUCATION PRGM	45,483	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,072,587	445,004	427,080	229,417	926,229
31.00	03100	INTENSIVE CARE UNIT	684,162	93,583	89,814	35,933	280,515
41.00	04100	SUBPROVIDER - IRF	482,854	72,791	69,859	0	184,024
43.00	04300	NURSERY	160,948	5,386	5,169	0	57,813
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,068,543	327,097	313,922	117,901	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	444,518	326,821	313,657	78,800	135,779
53.00	05300	ANESTHESIOLOGY	48,483	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	963,826	29,710	28,513	19,905	49,874
56.00	05600	RADIOISOTOPE	70,986	7,889	7,571	2,279	5,700
57.00	05700	CT SCAN	343,162	106,222	101,944	33,321	83,259
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	146,589	22,065	21,176	6,505	16,285
59.00	05900	CARDIAC CATHETERIZATION	381,781	24,483	23,497	7,748	0
60.00	06000	LABORATORY	1,318,478	78,803	75,629	0	39,085
65.00	06500	RESPIRATORY THERAPY	401,976	47,714	45,792	0	97,305
66.00	06600	PHYSICAL THERAPY	530,719	84,836	81,419	3,883	98,119
67.00	06700	OCCUPATIONAL THERAPY	329,079	153,099	146,932	43,837	3,257
68.00	06800	SPEECH PATHOLOGY	251,434	59,855	57,444	1,510	2,036
68.01	03040	AUDIOLOGY	27,883	2,428	2,330	374	407
69.00	06900	ELECTROCARDIOLOGY	190,831	0	0	3,454	0
69.01	03160	CARDIOPULMONARY	173,995	48,647	46,688	0	13,232
70.00	07000	ELECTROENCEPHALOGRAPHY	16,467	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,553,215	0	0	0	0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	458,406	0	0	0	0
74.00	07400	RENAL DIALYSIS	68,741	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,019,210	57,045	54,747	0	0
91.00	09100	EMERGENCY	1,756,036	226,780	217,646	106,240	260,158
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	317,534	9,744	9,352	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,759,311	2,787,334	2,492,273	703,644	2,318,014
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,393	11,197	10,746	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	102,711	480,558	461,202	0	0
193.00	19300	NONPAID WORKERS	34,348	160,701	154,229	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	23,898,763	3,439,790	3,118,450	703,644	2,318,014

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0289

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

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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	1,113,640					10.00
11.00	01100	0	1,736,962				11.00
13.00	01300	0	166,619	1,114,161			13.00
14.00	01400	0	79,199	0	1,769,164		14.00
15.00	01500	0	56,677	0	2,079	7,398,614	15.00
16.00	01600	0	116,148	0	7	0	16.00
17.00	01700	0	0	0	0	0	17.00
23.00	02300	0	50,923	0	2	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	861,899	455,139	387,990	38,092	15,147	30.00
31.00	03100	92,139	89,187	58,781	16,626	1,877	31.00
41.00	04100	159,602	77,514	37,978	2,433	791	41.00
43.00	04300	0	13,193	17,749	2,286	115	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	57,499	214,893	74,092	1,083	50.00
52.00	05200	0	30,948	41,605	5,363	271	52.00
53.00	05300	0	25,071	0	5,687	0	53.00
54.00	05400	0	30,167	0	3,387	0	54.00
56.00	05600	0	3,452	0	538	0	56.00
57.00	05700	0	50,471	0	8,178	0	57.00
58.00	05800	0	9,864	0	194	0	58.00
59.00	05900	0	0	39,696	2,257	439	59.00
60.00	06000	0	68,966	0	199,250	0	60.00
65.00	06500	0	63,047	0	8,809	0	65.00
66.00	06600	0	23,920	60,498	1,130	0	66.00
67.00	06700	0	15,371	38,933	322	0	67.00
68.00	06800	0	9,289	23,474	35	0	68.00
68.01	03040	0	2,302	0	270	0	68.01
69.00	06900	0	24,331	0	595	0	69.00
69.01	03160	0	51,909	18,130	1,132	0	69.01
70.00	07000	0	0	0	29	0	70.00
71.00	07100	0	0	0	1,371,251	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	7,378,122	73.00
74.00	07400	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	1,428	0	90.00
91.00	09100	0	140,644	174,434	23,027	769	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	665	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00		1,113,640	1,711,850	1,114,161	1,769,164	7,398,614	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	25,112	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		1,113,640	1,736,962	1,114,161	1,769,164	7,398,614	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0289

Period:
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To 12/31/2018

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Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PARAMEDICAL EDUCATION PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		16.00	17.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
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	2,156,581				16.00
17.00	01700	SOCIAL SERVICE	0	0			17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	0	0	291,731		23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	165,574	0	0	20,219,025	30.00
31.00	03100	INTENSIVE CARE UNIT	20,312	0	0	4,400,974	31.00
41.00	04100	SUBPROVIDER - IRF	25,094	0	0	3,186,495	41.00
43.00	04300	NURSERY	18,087	0	0	971,916	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	276,225	0	0	12,334,345	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	42,471	0	0	3,329,156	52.00
53.00	05300	ANESTHESIOLOGY	46,400	0	0	333,843	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	138,633	0	0	5,403,043	54.00
56.00	05600	RADIOISOTOPE	15,861	0	0	419,118	56.00
57.00	05700	CT SCAN	232,097	0	0	2,432,318	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	45,311	0	0	897,495	58.00
59.00	05900	CARDIAC CATHETERIZATION	41,571	0	0	2,160,979	59.00
60.00	06000	LABORATORY	272,863	0	0	7,715,106	60.00
65.00	06500	RESPIRATORY THERAPY	55,681	0	0	2,446,558	65.00
66.00	06600	PHYSICAL THERAPY	45,785	0	0	3,209,411	66.00
67.00	06700	OCCUPATIONAL THERAPY	27,604	0	0	2,171,620	67.00
68.00	06800	SPEECH PATHOLOGY	11,932	0	0	1,496,759	68.00
68.01	03040	AUDIOLOGY	3,977	0	0	159,711	68.01
69.00	06900	ELECTROCARDIOLOGY	59,705	0	0	1,098,414	69.00
69.01	03160	CARDIOPULMONARY	5,540	0	0	1,106,474	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	7,623	0	0	94,834	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	94,932	0	0	14,983,849	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	177,411	0	0	9,982,505	73.00
74.00	07400	RENAL DIALYSIS	3,977	0	0	367,917	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	55,018	0	0	10,858,686	90.00
91.00	09100	EMERGENCY	262,068	0	291,731	11,000,603	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	4,829	0	0	1,705,732	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,156,581	0	291,731	124,486,886	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	34,613	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,510,664	192.00
193.00	19300	NONPAID WORKERS	0	0	0	496,779	193.00
200.00		Cross Foot Adjustments			0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,156,581	0	291,731	126,528,942	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0289

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

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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
41.00	04100	SUBPROVIDER - IRF	41.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
68.01	03040	AUDIOLOGY	68.01
69.00	06900	ELECTROCARDIOLOGY	69.00
69.01	03160	CARDIOPULMONARY	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
193.00	19300	NONPAID WORKERS	193.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0289

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

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Part II
Date/Time Prepared:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
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	12,146	26,157	38,303	38,303 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	105,571	596,755	961,038	1,663,364	5,951 5.00
6.00 00600	MAINTENANCE & REPAIRS	80	153,593	406,685	560,358	815 6.00
7.00 00700	OPERATION OF PLANT	0	174,819	0	174,819	0 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	2,073	0	2,073	43 8.00
9.00 00900	HOUSEKEEPING	0	28,885	5,824	34,709	873 9.00
10.00 01000	DIETARY	719	103,599	3,584	107,902	180 10.00
11.00 01100	CAFETERIA	0	0	8,139	8,139	410 11.00
13.00 01300	NURSING ADMINISTRATION	0	14,121	0	14,121	431 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	52,351	100,144	58,693	211,188	539 14.00
15.00 01500	PHARMACY	273,871	23,902	108,090	405,863	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	64,008	1,874	65,882	660 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
23.00 02300	PARAMEDICAL EDUCATION PRGM	0	0	0	0	117 23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	158	408,449	152,300	560,907	6,845 30.00
31.00 03100	INTENSIVE CARE UNIT	0	85,896	51,232	137,128	1,508 31.00
41.00 04100	SUBPROVIDER - IRF	0	66,811	872	67,683	727 41.00
43.00 04300	NURSERY	0	4,944	14,114	19,058	370 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	161,745	300,228	243,443	705,416	3,586 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	299,975	33,111	333,086	867 52.00
53.00 05300	ANESTHESIOLOGY	8,221	0	10,633	18,854	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	282,673	27,270	232,749	542,692	1,585 54.00
56.00 05600	RADIOISOTOPE	0	7,241	9,334	16,575	117 56.00
57.00 05700	CT SCAN	233,814	97,497	234,125	565,436	293 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	238,920	20,253	26,668	285,841	117 58.00
59.00 05900	CARDIAC CATHETERIZATION	177,397	22,472	219,237	419,106	547 59.00
60.00 06000	LABORATORY	13,846	72,329	237,524	323,699	1,149 60.00
65.00 06500	RESPIRATORY THERAPY	23,549	43,795	59,617	126,961	807 65.00
66.00 06600	PHYSICAL THERAPY	7,892	77,867	11,866	97,625	1,226 66.00
67.00 06700	OCCUPATIONAL THERAPY	5,000	140,523	2,789	148,312	714 67.00
68.00 06800	SPEECH PATHOLOGY	3,023	54,938	773	58,734	570 68.00
68.01 03040	AUDIOLOGY	586	2,229	3,914	6,729	136 68.01
69.00 06900	ELECTROCARDIOLOGY	25,920	0	59,068	84,988	356 69.00
69.01 03160	CARDIOPULMONARY	0	44,651	19,165	63,816	385 69.01
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	5,404	5,404	36 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,136 73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	0 74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	769,629	52,359	180,472	1,002,460	548 90.00
91.00 09100	EMERGENCY	0	208,152	76,744	284,896	3,928 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	8,944	0	8,944	731 101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	0 113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	2,384,965	3,320,868	3,465,238	9,171,071	38,303 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,277	0	10,277	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	441,081	0	441,081	0 192.00
193.00 19300	NONPAID WORKERS	0	147,501	0	147,501	0 193.00
200.00	Cross Foot Adjustments	0	0	0	0	0 200.00
201.00	Negative Cost Centers	0	0	0	0	0 201.00
202.00	TOTAL (sum lines 118 through 201)	2,384,965	3,919,727	3,465,238	9,769,930	38,303 202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0289	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part II Date/Time Prepared: 5/30/2019 11:39 am		
Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING
			5.00	6.00	7.00	8.00	9.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,669,315				5.00
6.00	00600	MAINTENANCE & REPAIRS	45,381	606,554			6.00
7.00	00700	OPERATION OF PLANT	38,629	33,585	247,033		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,225	398	172	11,911	8.00
9.00	00900	HOUSEKEEPING	29,768	5,549	2,393	0	73,292
10.00	01000	DIETARY	11,774	19,903	8,581	0	0
11.00	01100	CAFETERIA	22,916	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	12,103	2,713	1,170	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	19,089	19,239	8,295	212	528
15.00	01500	PHARMACY	95,825	4,592	1,980	0	805
16.00	01600	MEDICAL RECORDS & LIBRARY	24,815	12,297	5,302	0	721
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
23.00	02300	PARAMEDICAL EDUCATION PRGM	3,177	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	214,649	78,470	33,832	3,884	29,285
31.00	03100	INTENSIVE CARE UNIT	47,787	16,502	7,115	608	8,869
41.00	04100	SUBPROVIDER - IRF	33,726	12,836	5,534	0	5,819
43.00	04300	NURSERY	11,242	950	410	0	1,828
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	144,483	57,678	24,868	1,996	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	31,049	57,630	24,847	1,334	4,293
53.00	05300	ANESTHESIOLOGY	3,386	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	67,321	5,239	2,259	337	1,577
56.00	05600	RADIOISOTOPE	4,958	1,391	600	39	180
57.00	05700	CT SCAN	23,969	18,731	8,076	564	2,633
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	10,239	3,891	1,678	110	515
59.00	05900	CARDIAC CATHETERIZATION	26,667	4,317	1,861	131	0
60.00	06000	LABORATORY	92,093	13,896	5,991	0	1,236
65.00	06500	RESPIRATORY THERAPY	28,077	8,414	3,628	0	3,077
66.00	06600	PHYSICAL THERAPY	37,070	14,959	6,450	66	3,102
67.00	06700	OCCUPATIONAL THERAPY	22,985	26,997	11,639	742	103
68.00	06800	SPEECH PATHOLOGY	17,562	10,554	4,551	26	64
68.01	03040	AUDIOLOGY	1,948	428	185	6	13
69.00	06900	ELECTROCARDIOLOGY	13,329	0	0	58	0
69.01	03160	CARDIOPULMONARY	12,153	8,578	3,698	0	418
70.00	07000	ELECTROENCEPHALOGRAPHY	1,150	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	178,337	0	0	0	0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	32,019	0	0	0	0
74.00	07400	RENAL DIALYSIS	4,801	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	141,038	10,059	4,337	0	0
91.00	09100	EMERGENCY	122,656	39,989	17,241	1,798	8,226
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	22,179	1,718	741	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,659,575	491,503	197,434	11,911	73,292
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	167	1,974	851	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,174	84,740	36,531	0	0
193.00	19300	NONPAID WORKERS	2,399	28,337	12,217	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	1,669,315	606,554	247,033	11,911	73,292

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0289		Period: From 01/01/2018 To 12/31/2018		Worksheet B Part II Date/Time Prepared: 5/30/2019 11:39 am	
Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	148,340					10.00
11.00	01100	CAFETERIA	0	31,465				11.00
13.00	01300	NURSING ADMINISTRATION	0	3,018	33,556			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,435	0	260,525		14.00
15.00	01500	PHARMACY	0	1,027	0	306	510,398	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,104	0	1	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	0	922	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	114,808	8,245	11,684	5,610	1,045	30.00
31.00	03100	INTENSIVE CARE UNIT	12,273	1,616	1,770	2,448	130	31.00
41.00	04100	SUBPROVIDER - I RF	21,259	1,404	1,144	358	55	41.00
43.00	04300	NURSERY	0	239	535	337	8	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,042	6,472	10,911	75	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	561	1,253	790	19	52.00
53.00	05300	ANESTHESIOLOGY	0	454	0	837	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	546	0	499	0	54.00
56.00	05600	RADIOISOTOPE	0	63	0	79	0	56.00
57.00	05700	CT SCAN	0	914	0	1,204	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	179	0	29	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	1,196	332	30	59.00
60.00	06000	LABORATORY	0	1,249	0	29,342	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,142	0	1,297	0	65.00
66.00	06600	PHYSICAL THERAPY	0	433	1,822	166	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	278	1,173	47	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	168	707	5	0	68.00
68.01	03040	AUDIOLOGY	0	42	0	40	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	441	0	88	0	69.00
69.01	03160	CARDIOPULMONARY	0	940	546	167	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	4	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	201,929	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	508,983	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	210	0	90.00
91.00	09100	EMERGENCY	0	2,548	5,254	3,391	53	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	98	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	148,340	31,010	33,556	260,525	510,398	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	455	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	148,340	31,465	33,556	260,525	510,398	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0289

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

Worksheet B
Part II
Date/Time Prepared:
5/30/2019 11:39 am

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PARAMEDICAL EDUCATION PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		16.00	17.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
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	111,782				16.00
17.00	01700	SOCIAL SERVICE	0	0			17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	0	0	4,216		23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,582	0		1,077,846	0 30.00
31.00	03100	INTENSIVE CARE UNIT	1,053	0		238,807	0 31.00
41.00	04100	SUBPROVIDER - IRF	1,301	0		151,846	0 41.00
43.00	04300	NURSERY	937	0		35,914	0 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	14,318	0		970,845	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,201	0		457,930	0 52.00
53.00	05300	ANESTHESIOLOGY	2,405	0		25,936	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,186	0		629,241	0 54.00
56.00	05600	RADIOISOTOPE	822	0		24,824	0 56.00
57.00	05700	CT SCAN	12,030	0		633,850	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,349	0		304,948	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	2,155	0		456,342	0 59.00
60.00	06000	LABORATORY	14,143	0		482,798	0 60.00
65.00	06500	RESPIRATORY THERAPY	2,886	0		176,289	0 65.00
66.00	06600	PHYSICAL THERAPY	2,373	0		165,292	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	1,431	0		214,421	0 67.00
68.00	06800	SPEECH PATHOLOGY	618	0		93,559	0 68.00
68.01	03040	AUDIOLOGY	206	0		9,733	0 68.01
69.00	06900	ELECTROCARDIOLOGY	3,095	0		102,355	0 69.00
69.01	03160	CARDIOPULMONARY	287	0		90,988	0 69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	395	0		6,989	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,921	0		385,187	0 71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,196	0		551,334	0 73.00
74.00	07400	RENAL DIALYSIS	206	0		5,007	0 74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,852	0		1,161,504	0 90.00
91.00	09100	EMERGENCY	13,584	0		503,564	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	250	0		34,661	0 101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	111,782	0	0	8,992,010	0 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		13,269	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		569,981	0 192.00
193.00	19300	NONPAID WORKERS	0	0		190,454	0 193.00
200.00		Cross Foot Adjustments			4,216	4,216	0 200.00
201.00		Negative Cost Centers	0	0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	111,782	0	4,216	9,769,930	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0289	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part II Date/Time Prepared: 5/30/2019 11:39 am
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
41.00	04100	SUBPROVIDER - IRF	41.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
68.01	03040	AUDIOLOGY	68.01
69.00	06900	ELECTROCARDIOLOGY	69.00
69.01	03160	CARDIOPULMONARY	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
193.00	19300	NONPAID WORKERS	193.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0289

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

Worksheet B-1

Date/Time Prepared:
5/30/2019 11:39 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	402,760				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		3,320,723			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,248	25,066	53,486,677		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	61,318	920,957	8,311,800	-23,898,763	102,630,179
6.00 00600	MAINTENANCE & REPAIRS	15,782	389,725	1,138,429	0	2,790,083
7.00 00700	OPERATION OF PLANT	17,963	0	0	0	2,374,948
8.00 00800	LAUNDRY & LINEN SERVICE	213	0	59,939	0	567,150
9.00 00900	HOUSEKEEPING	2,968	5,581	1,219,868	0	1,830,164
10.00 01000	DIETARY	10,645	3,435	251,930	0	723,880
11.00 01100	CAFETERIA	0	7,800	572,227	0	1,408,885
13.00 01300	NURSING ADMINISTRATION	1,451	0	602,396	0	744,115
14.00 01400	CENTRAL SERVICES & SUPPLY	10,290	56,245	753,302	0	1,173,624
15.00 01500	PHARMACY	2,456	103,582	0	0	5,891,473
16.00 01600	MEDICAL RECORDS & LIBRARY	6,577	1,796	922,419	0	1,525,686
17.00 01700	SOCIAL SERVICE	0	0	0	0	0
23.00 02300	PARAMEDICAL EDUCATION PRGM	0	0	163,177	0	195,323
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	41,969	145,948	9,550,268	0	13,194,867
31.00 03100	INTENSIVE CARE UNIT	8,826	49,095	2,106,003	0	2,938,045
41.00 04100	SUBPROVIDER - IRF	6,865	836	1,015,395	0	2,073,555
43.00 04300	NURSERY	508	13,525	516,369	0	691,170
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	30,849	233,290	5,008,436	0	8,883,090
52.00 05200	DELIVERY ROOM & LABOR ROOM	30,823	31,730	1,210,872	0	1,908,923
53.00 05300	ANESTHESIOLOGY	0	10,190	0	0	208,202
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,802	223,042	2,213,251	0	4,139,028
56.00 05600	RADIOISOTOPE	744	8,945	163,171	0	304,842
57.00 05700	CT SCAN	10,018	224,361	409,769	0	1,473,664
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	2,081	25,556	163,393	0	629,506
59.00 05900	CARDIAC CATHETERIZATION	2,309	210,094	764,217	0	1,639,507
60.00 06000	LABORATORY	7,432	227,618	1,604,672	0	5,662,032
65.00 06500	RESPIRATORY THERAPY	4,500	57,131	1,127,709	0	1,726,234
66.00 06600	PHYSICAL THERAPY	8,001	11,371	1,712,388	0	2,279,102
67.00 06700	OCCUPATIONAL THERAPY	14,439	2,673	996,654	0	1,413,186
68.00 06800	SPEECH PATHOLOGY	5,645	741	795,395	0	1,079,750
68.01 03040	AUDIOLOGY	229	3,751	189,413	0	119,740
69.00 06900	ELECTROCARDIOLOGY	0	56,605	496,855	0	819,498
69.01 03160	CARDIOPULMONARY	4,588	18,366	537,474	0	747,201
70.00 07000	ELECTROENCEPHALOGRAPHY	0	5,179	50,532	0	70,715
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	10,964,451
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	1,586,089	0	1,968,566
74.00 07400	RENAL DIALYSIS	0	0	0	0	295,199
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	5,380	172,946	765,720	0	8,671,238
91.00 09100	EMERGENCY	21,388	73,543	5,485,781	0	7,541,070
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	919	0	1,021,364	0	1,363,608
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	341,226	3,320,723	53,486,677	-23,898,763	102,031,320
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,056	0	0	0	10,277
192.00 19200	PHYSICIANS' PRIVATE OFFICES	45,322	0	0	0	441,081
193.00 19300	NONPAID WORKERS	15,156	0	0	0	147,501
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	3,919,727	3,465,238	12,898,039		23,898,763
203.00	Unit cost multiplier (Wkst. B, Part I)	9.732166	1.043519	0.241145		0.232863
204.00	Cost to be allocated (per Wkst. B, Part II)			38,303		1,669,315
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000716		0.016265
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0289

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

Worksheet B-1

Date/Time Prepared:
5/30/2019 11:39 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00	4.00				
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)				5A	5.00		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0289

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

Worksheet B-1
Date/Time Prepared:
5/30/2019 11:39 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	324,412					6.00
7.00	00700	17,963	306,449				7.00
8.00	00800	213	213	1,135,180			8.00
9.00	00900	2,968	2,968		11,387		9.00
10.00	01000	10,645	10,645			100,415	10.00
11.00	01100	0	0		0	0	11.00
13.00	01300	1,451	1,451		0	0	13.00
14.00	01400	10,290	10,290	20,226	82	0	14.00
15.00	01500	2,456	2,456		125	0	15.00
16.00	01600	6,577	6,577		112	0	16.00
17.00	01700	0	0		0	0	17.00
23.00	02300	0	0		0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	41,969	41,969	370,115	4,550	77,716	30.00
31.00	03100	8,826	8,826	57,971	1,378	8,308	31.00
41.00	04100	6,865	6,865		904	14,391	41.00
43.00	04300	508	508		284	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	30,849	30,849	190,208	0	0	50.00
52.00	05200	30,823	30,823	127,127	667	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	2,802	2,802	32,113	245	0	54.00
56.00	05600	744	744	3,676	28	0	56.00
57.00	05700	10,018	10,018	53,756	409	0	57.00
58.00	05800	2,081	2,081	10,494	80	0	58.00
59.00	05900	2,309	2,309	12,500	0	0	59.00
60.00	06000	7,432	7,432		192	0	60.00
65.00	06500	4,500	4,500		478	0	65.00
66.00	06600	8,001	8,001	6,265	482	0	66.00
67.00	06700	14,439	14,439	70,721	16	0	67.00
68.00	06800	5,645	5,645	2,436	10	0	68.00
68.01	03040	229	229	604	2	0	68.01
69.00	06900	0	0	5,572	0	0	69.00
69.01	03160	4,588	4,588		65	0	69.01
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	5,380	5,380	0	0	0	90.00
91.00	09100	21,388	21,388	171,396	1,278	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	919	919	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		262,878	244,915	1,135,180	11,387	100,415	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	1,056	1,056	0	0	0	190.00
192.00	19200	45,322	45,322	0	0	0	192.00
193.00	19300	15,156	15,156	0	0	0	193.00
200.00							200.00
201.00							201.00
202.00		3,439,790	3,118,450	703,644	2,318,014	1,113,640	202.00
203.00		10.603153	10.176082	0.619852	203.566699	11.090375	203.00
204.00		606,554	247,033	11,911	73,292	148,340	204.00
205.00		1.869703	0.806115	0.010493	6.436463	1.477269	205.00
206.00							206.00
207.00							207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0289

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

Worksheet B-1
Date/Time Prepared:
5/30/2019 11:39 am

Cost Center Description		CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	42,262					11.00
13.00	01300	4,054	11,676				13.00
14.00	01400	1,927	0	14,146,139			14.00
15.00	01500	1,379	0	16,624	3,471,944		15.00
16.00	01600	2,826	0	57	0	45,548	16.00
17.00	01700	0	0	0	0	0	17.00
23.00	02300	1,239	0	13	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	11,074	4,066	304,585	7,108	3,497	30.00
31.00	03100	2,170	616	132,939	881	429	31.00
41.00	04100	1,886	398	19,455	371	530	41.00
43.00	04300	321	186	18,278	54	382	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,399	2,252	592,437	508	5,834	50.00
52.00	05200	753	436	42,883	127	897	52.00
53.00	05300	610	0	45,470	0	980	53.00
54.00	05400	734	0	27,079	0	2,928	54.00
56.00	05600	84	0	4,305	0	335	56.00
57.00	05700	1,228	0	65,388	0	4,902	57.00
58.00	05800	240	0	1,550	0	957	58.00
59.00	05900	0	416	18,049	206	878	59.00
60.00	06000	1,678	0	1,593,198	0	5,763	60.00
65.00	06500	1,534	0	70,439	0	1,176	65.00
66.00	06600	582	634	9,033	0	967	66.00
67.00	06700	374	408	2,573	0	583	67.00
68.00	06800	226	246	283	0	252	68.00
68.01	03040	56	0	2,156	0	84	68.01
69.00	06900	592	0	4,755	0	1,261	69.00
69.01	03160	1,263	190	9,053	0	117	69.01
70.00	07000	0	0	228	0	161	70.00
71.00	07100	0	0	10,964,451	0	2,005	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	3,462,328	3,747	73.00
74.00	07400	0	0	0	0	84	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	11,418	0	1,162	90.00
91.00	09100	3,422	1,828	184,120	361	5,535	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	5,320	0	102	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		41,651	11,676	14,146,139	3,471,944	45,548	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	611	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
200.00							200.00
201.00							201.00
202.00		1,736,962	1,114,161	1,769,164	7,398,614	2,156,581	202.00
203.00		41.099853	95.423176	0.125063	2.130972	47.347436	203.00
204.00		31,465	33,556	260,525	510,398	111,782	204.00
205.00		0.744522	2.873929	0.018417	0.147006	2.454158	205.00
206.00							206.00
207.00							207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0289

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

Worksheet B-1
Date/Time Prepared:
5/30/2019 11:39 am

Cost Center Description		SOCIAL SERVICE (TIME SPENT)	PARAMEDICAL EDUCATION PRGM (ASSIGNED TIME)	
		17.00	23.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	0 100	23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0 0	30.00
31.00	03100	INTENSIVE CARE UNIT	0 0	31.00
41.00	04100	SUBPROVIDER - I RF	0 0	41.00
43.00	04300	NURSERY	0 0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0 0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0 0	52.00
53.00	05300	ANESTHESIOLOGY	0 0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0 0	54.00
56.00	05600	RADIOISOTOPE	0 0	56.00
57.00	05700	CT SCAN	0 0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0 0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0 0	59.00
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
68.01	03040	AUDIOLOGY	0 0	68.01
69.00	06900	ELECTROCARDIOLOGY	0 0	69.00
69.01	03160	CARDIOPULMONARY	0 0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0 0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0 0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0 0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0 0	73.00
74.00	07400	RENAL DIALYSIS	0 0	74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0 0	90.00
91.00	09100	EMERGENCY	0 100	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0 0	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0 100	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0 0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0 0	192.00
193.00	19300	NONPAID WORKERS	0 0	193.00
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0 291,731	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000 2,917.310000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0 4,216	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000 42.160000	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)	0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0289

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

Worksheet C
Part I
Date/Time Prepared:
5/30/2019 11:39 am

		Title XVIII		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	20,219,025	20,219,025	0	20,219,025	30.00	
31.00	03100 INTENSIVE CARE UNIT	4,400,974	4,400,974	0	4,400,974	31.00	
41.00	04100 SUBPROVIDER - I RF	3,186,495	3,186,495	0	3,186,495	41.00	
43.00	04300 NURSERY	971,916	971,916	0	971,916	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	12,334,345	12,334,345	0	12,334,345	50.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	3,329,156	3,329,156	0	3,329,156	52.00	
53.00	05300 ANESTHESIOLOGY	333,843	333,843	72,795	406,638	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,403,043	5,403,043	64,312	5,467,355	54.00	
56.00	05600 RADIOISOTOPE	419,118	419,118	0	419,118	56.00	
57.00	05700 CT SCAN	2,432,318	2,432,318	0	2,432,318	57.00	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	897,495	897,495	0	897,495	58.00	
59.00	05900 CARDIAC CATHETERIZATION	2,160,979	2,160,979	10,192	2,171,171	59.00	
60.00	06000 LABORATORY	7,715,106	7,715,106	0	7,715,106	60.00	
65.00	06500 RESPIRATORY THERAPY	2,446,558	2,446,558	0	2,446,558	65.00	
66.00	06600 PHYSICAL THERAPY	3,209,411	3,209,411	0	3,209,411	66.00	
67.00	06700 OCCUPATIONAL THERAPY	2,171,620	2,171,620	0	2,171,620	67.00	
68.00	06800 SPEECH PATHOLOGY	1,496,759	1,496,759	0	1,496,759	68.00	
68.01	03040 AUDIOLOGY	159,711	159,711	0	159,711	68.01	
69.00	06900 ELECTROCARDIOLOGY	1,098,414	1,098,414	0	1,098,414	69.00	
69.01	03160 CARDIOPULMONARY	1,106,474	1,106,474	0	1,106,474	69.01	
70.00	07000 ELECTROENCEPHALOGRAPHY	94,834	94,834	0	94,834	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	14,983,849	14,983,849	0	14,983,849	71.00	
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	9,982,505	9,982,505	0	9,982,505	73.00	
74.00	07400 RENAL DIALYSIS	367,917	367,917	0	367,917	74.00	
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	10,858,686	10,858,686	0	10,858,686	90.00	
91.00	09100 EMERGENCY	11,000,603	11,000,603	0	11,000,603	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3,456,572	3,456,572	0	3,456,572	92.00	
OTHER REIMBURSABLE COST CENTERS							
101.00	10100 HOME HEALTH AGENCY	1,705,732	1,705,732	0	1,705,732	101.00	
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE					113.00	
200.00	Subtotal (see instructions)	127,943,458	127,943,458	147,299	128,090,757	200.00	
201.00	Less Observation Beds	3,456,572	3,456,572		3,456,572	201.00	
202.00	Total (see instructions)	124,486,886	124,486,886	147,299	124,634,185	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0289	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/30/2019 11:39 am
		Title XVIII	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
9.00	10.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,418,081		28,418,081	30.00
31.00	03100	INTENSIVE CARE UNIT	5,508,200		5,508,200	31.00
41.00	04100	SUBPROVIDER - IRF	6,803,767		6,803,767	41.00
43.00	04300	NURSERY	4,911,739		4,911,739	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,711,592	56,235,738	74,947,330	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,916,121	601,786	11,517,907	52.00
53.00	05300	ANESTHESIOLOGY	2,890,363	9,693,714	12,584,077	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,171,526	31,444,980	37,616,506	54.00
56.00	05600	RADIOISOTOPE	747,226	3,558,951	4,306,177	56.00
57.00	05700	CT SCAN	5,687,449	57,281,184	62,968,633	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,968,843	10,323,553	12,292,396	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,998,848	5,283,761	11,282,609	59.00
60.00	06000	LABORATORY	25,281,393	48,753,668	74,035,061	60.00
65.00	06500	RESPIRATORY THERAPY	9,017,931	6,089,677	15,107,608	65.00
66.00	06600	PHYSICAL THERAPY	6,139,437	6,278,854	12,418,291	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,518,476	2,974,337	7,492,813	67.00
68.00	06800	SPEECH PATHOLOGY	977,053	2,255,646	3,232,699	68.00
68.01	03040	AUDIOLOGY	0	1,081,226	1,081,226	68.01
69.00	06900	ELECTROCARDIOLOGY	5,314,320	10,879,071	16,193,391	69.00
69.01	03160	CARDIOPULMONARY	305	1,500,958	1,501,263	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	67,625	2,003,708	2,071,333	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,961,671	12,794,923	25,756,594	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,597,684	33,539,093	48,136,777	73.00
74.00	07400	RENAL DIALYSIS	1,000,384	75,109	1,075,493	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	46,113	14,885,429	14,931,542	90.00
91.00	09100	EMERGENCY	12,963,985	58,134,113	71,098,098	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,345,570	12,156,118	16,501,688	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,305,262	1,305,262	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)	195,965,702	389,130,859	585,096,561	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	195,965,702	389,130,859	585,096,561	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0289	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/30/2019 11:39 am
		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
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.164574		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.289042		52.00
53.00	05300 ANESTHESIOLOGY	0.032314		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.145345		54.00
56.00	05600 RADIOISOTOPE	0.097329		56.00
57.00	05700 CT SCAN	0.038627		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.073012		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.192435		59.00
60.00	06000 LABORATORY	0.104209		60.00
65.00	06500 RESPIRATORY THERAPY	0.161942		65.00
66.00	06600 PHYSICAL THERAPY	0.258442		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.289827		67.00
68.00	06800 SPEECH PATHOLOGY	0.463006		68.00
68.01	03040 AUDIOLOGY	0.147713		68.01
69.00	06900 ELECTROCARDIOLOGY	0.067831		69.00
69.01	03160 CARDIOPULMONARY	0.737029		69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.045784		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.581748		71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.207378		73.00
74.00	07400 RENAL DIALYSIS	0.342091		74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.727231		90.00
91.00	09100 EMERGENCY	0.154724		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.209468		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-0289	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part I Date/Time Prepared: 5/30/2019 11:39 am
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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	
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,077,846	0	1,077,846	26,223	41.10	30.00
31.00	INTENSIVE CARE UNIT	238,807	0	238,807	2,379	100.38	31.00
41.00	SUBPROVIDER - IRF	151,846	0	151,846	4,121	36.85	41.00
43.00	NURSERY	35,914		35,914	3,168	11.34	43.00
200.00	Total (lines 30 through 199)	1,504,413		1,504,413	35,891		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	8,378	344,336				
31.00	INTENSIVE CARE UNIT	815	81,810				
41.00	SUBPROVIDER - IRF	2,783	102,554				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	11,976	528,700				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0289	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Prepared: 5/30/2019 11:39 am
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Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	970,845	74,947,330	0.012954	5,833,560	75,568	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	457,930	11,517,907	0.039758	7,645	304	52.00
53.00	05300	ANESTHESIOLOGY	25,936	12,584,077	0.002061	911,809	1,879	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	629,241	37,616,506	0.016728	3,676,714	61,504	54.00
56.00	05600	RADIOISOTOPE	24,824	4,306,177	0.005765	472,327	2,723	56.00
57.00	05700	CT SCAN	633,850	62,968,633	0.010066	5,586,339	56,232	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	304,948	12,292,396	0.024808	894,594	22,193	58.00
59.00	05900	CARDIAC CATHETERIZATION	456,342	11,282,609	0.040446	1,538,503	62,226	59.00
60.00	06000	LABORATORY	482,798	74,035,061	0.006521	12,058,122	78,631	60.00
65.00	06500	RESPIRATORY THERAPY	176,289	15,107,608	0.011669	4,326,121	50,482	65.00
66.00	06600	PHYSICAL THERAPY	165,292	12,418,291	0.013310	1,716,203	22,843	66.00
67.00	06700	OCCUPATIONAL THERAPY	214,421	7,492,813	0.028617	931,185	26,648	67.00
68.00	06800	SPEECH PATHOLOGY	93,559	3,232,699	0.028941	248,012	7,178	68.00
68.01	03040	AUDIOLOGY	9,733	1,081,226	0.009002	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	102,355	16,193,391	0.006321	2,886,803	18,247	69.00
69.01	03160	CARDIOPULMONARY	90,988	1,501,263	0.006068	305	18	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	6,989	2,071,333	0.003374	27,479	93	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	385,187	25,756,594	0.014955	4,927,613	73,692	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	551,334	48,136,777	0.011453	6,010,344	68,836	73.00
74.00	07400	RENAL DIALYSIS	5,007	1,075,493	0.004656	544,809	2,537	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,161,504	14,931,542	0.077789	22,599	1,758	90.00
91.00	09100	EMERGENCY	503,564	71,098,098	0.007083	5,731,339	40,595	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	184,266	16,501,688	0.011166	1,838,760	20,532	92.00
200.00		Total (lines 50 through 199)	7,637,202	538,149,512		60,191,185	694,719	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0289	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part III Date/Time Prepared: 5/30/2019 11:39 am
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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	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00	
43.00	04300	NURSERY	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	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	26,223	0.00	8,378 30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	2,379	0.00	815 31.00	
41.00	04100	SUBPROVIDER - IRF	0	0	4,121	0.00	2,783 41.00	
43.00	04300	NURSERY	0	0	3,168	0.00	0 43.00	
200.00		Total (lines 30 through 199)	0	0	35,891		11,976 200.00	
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
41.00	04100	SUBPROVIDER - IRF	0					41.00
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: 14-0289	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/30/2019 11:39 am
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Cost Center Description	Title XVIII			Hospital		PPS		
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health			
	1.00	2A	2.00	3A	3.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
68.01	03040	AUDIOLOGY	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	291,731	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	291,731	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0289	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/30/2019 11:39 am
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Cost Center Description		Title XVIII			Hospital	PPS		
		All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	74,947,330	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	11,517,907	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	12,584,077	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	37,616,506	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	4,306,177	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	62,968,633	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	12,292,396	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	11,282,609	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	74,035,061	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	15,107,608	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	12,418,291	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	7,492,813	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,232,699	0.000000	68.00
68.01	03040	AUDIOLOGY	0	0	0	1,081,226	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	16,193,391	0.000000	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	1,501,263	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,071,333	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	25,756,594	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	48,136,777	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,075,493	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	14,931,542	0.000000	90.00
91.00	09100	EMERGENCY	0	291,731	291,731	71,098,098	0.004103	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	16,501,688	0.000000	92.00
200.00		Total (lines 50 through 199)	0	291,731	291,731	538,149,512		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0289	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/30/2019 11:39 am
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Cost Center Description		Title XVIII				Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	0.000000	5,833,560	0	11,202,635	0	50.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	7,645	0	120,979	0	52.00	
53.00	05300 ANESTHESIOLOGY	0.000000	911,809	0	1,854,746	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	3,676,714	0	5,082,440	0	54.00	
56.00	05600 RADIOISOTOPE	0.000000	472,327	0	1,042,894	0	56.00	
57.00	05700 CT SCAN	0.000000	5,586,339	0	12,769,670	0	57.00	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	894,594	0	2,507,386	0	58.00	
59.00	05900 CARDIAC CATHETERIZATION	0.000000	1,538,503	0	1,832,712	0	59.00	
60.00	06000 LABORATORY	0.000000	12,058,122	0	6,352,712	0	60.00	
65.00	06500 RESPIRATORY THERAPY	0.000000	4,326,121	0	1,486,380	0	65.00	
66.00	06600 PHYSICAL THERAPY	0.000000	1,716,203	0	139,992	0	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0.000000	931,185	0	82,885	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0.000000	248,012	0	11,218	0	68.00	
68.01	03040 AUDIOLOGY	0.000000	0	0	136,095	0	68.01	
69.00	06900 ELECTROCARDIOLOGY	0.000000	2,886,803	0	2,697,086	0	69.00	
69.01	03160 CARDIOPULMONARY	0.000000	305	0	593,749	0	69.01	
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	27,479	0	503,747	0	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	4,927,613	0	3,255,523	0	71.00	
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	6,010,344	0	10,851,557	0	73.00	
74.00	07400 RENAL DIALYSIS	0.000000	544,809	0	38,622	0	74.00	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000 CLINIC	0.000000	22,599	0	5,817,408	0	90.00	
91.00	09100 EMERGENCY	0.004103	5,731,339	23,516	8,991,044	36,890	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	1,838,760	0	2,809,692	0	92.00	
200.00	Total (lines 50 through 199)		60,191,185	23,516	80,181,172	36,890	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0289	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/30/2019 11:39 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.164574	11,202,635	0	0	1,843,662	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.289042	120,979	0	0	34,968	52.00
53.00	05300 ANESTHESIOLOGY	0.026529	1,854,746	0	0	49,205	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.143635	5,082,440	0	0	730,016	54.00
56.00	05600 RADIOISOTOPE	0.097329	1,042,894	0	0	101,504	56.00
57.00	05700 CT SCAN	0.038627	12,769,670	0	0	493,254	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.073012	2,507,386	0	0	183,069	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.191532	1,832,712	0	0	351,023	59.00
60.00	06000 LABORATORY	0.104209	6,352,712	0	0	662,010	60.00
65.00	06500 RESPIRATORY THERAPY	0.161942	1,486,380	0	0	240,707	65.00
66.00	06600 PHYSICAL THERAPY	0.258442	139,992	0	0	36,180	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.289827	82,885	0	0	24,022	67.00
68.00	06800 SPEECH PATHOLOGY	0.463006	11,218	0	0	5,194	68.00
68.01	03040 AUDIOLOGY	0.147713	136,095	0	0	20,103	68.01
69.00	06900 ELECTROCARDIOLOGY	0.067831	2,697,086	0	0	182,946	69.00
69.01	03160 CARDIOPULMONARY	0.737029	593,749	0	0	437,610	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.045784	503,747	0	0	23,064	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.581748	3,255,523	0	0	1,893,894	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.207378	10,851,557	0	10,735	2,250,374	73.00
74.00	07400 RENAL DIALYSIS	0.342091	38,622	0	0	13,212	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.727231	5,817,408	0	0	4,230,599	90.00
91.00	09100 EMERGENCY	0.154724	8,991,044	0	0	1,391,130	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.209468	2,809,692	0	0	588,541	92.00
200.00	Subtotal (see instructions)		80,181,172	0	10,735	15,786,287	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 - line 201)		80,181,172	0	10,735	15,786,287	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0289	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/30/2019 11:39 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
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
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
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
68.01	03040 AUDIOLOGY	0	0	68.01
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
69.01	03160 CARDIOPULMONARY	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2,226	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Subtotal (see instructions)	0	2,226	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	0	2,226	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 14-0289 Component CCN: 14-T289		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part II Date/Time Prepared: 5/30/2019 11:39 am	
			Title XVIII		Subprovider - IRF		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	970,845	74,947,330	0.012954	62,062	804	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	457,930	11,517,907	0.039758	0	0	52.00
53.00	05300	ANESTHESIOLOGY	25,936	12,584,077	0.002061	10,450	22	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	629,241	37,616,506	0.016728	148,046	2,477	54.00
56.00	05600	RADIOISOTOPE	24,824	4,306,177	0.005765	7,135	41	56.00
57.00	05700	CT SCAN	633,850	62,968,633	0.010066	101,110	1,018	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	304,948	12,292,396	0.024808	38,277	950	58.00
59.00	05900	CARDIAC CATHETERIZATION	456,342	11,282,609	0.040446	28,364	1,147	59.00
60.00	06000	LABORATORY	482,798	74,035,061	0.006521	548,201	3,575	60.00
65.00	06500	RESPIRATORY THERAPY	176,289	15,107,608	0.011669	156,759	1,829	65.00
66.00	06600	PHYSICAL THERAPY	165,292	12,418,291	0.013310	1,899,819	25,287	66.00
67.00	06700	OCCUPATIONAL THERAPY	214,421	7,492,813	0.028617	1,886,667	53,991	67.00
68.00	06800	SPEECH PATHOLOGY	93,559	3,232,699	0.028941	295,982	8,566	68.00
68.01	03040	AUDIOLOGY	9,733	1,081,226	0.009002	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	102,355	16,193,391	0.006321	21,425	135	69.00
69.01	03160	CARDIOPULMONARY	90,988	1,501,263	0.060608	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	6,989	2,071,333	0.003374	654	2	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	385,187	25,756,594	0.014955	112,114	1,677	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	551,334	48,136,777	0.011453	561,961	6,436	73.00
74.00	07400	RENAL DIALYSIS	5,007	1,075,493	0.004656	51,124	238	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,161,504	14,931,542	0.077789	0	0	90.00
91.00	09100	EMERGENCY	503,564	71,098,098	0.007083	24,478	173	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	16,501,688	0.000000	63,245	0	92.00
200.00		Total (lines 50 through 199)	7,452,936	538,149,512		6,017,873	108,368	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0289 Component CCN: 14-T289	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/30/2019 11:39 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
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
68.01	03040 AUDIOLOGY	0	0	0	0	0	68.01
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160 CARDIOPULMONARY	0	0	0	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	291,731	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50 through 199)	0	0	0	0	291,731	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0289 Component CCN: 14-T289	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/30/2019 11:39 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 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	74,947,330	0.000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	11,517,907	0.000000	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	12,584,077	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	37,616,506	0.000000	54.00
56.00 05600 RADIOISOTOPE	0	0	0	4,306,177	0.000000	56.00
57.00 05700 CT SCAN	0	0	0	62,968,633	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	12,292,396	0.000000	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	11,282,609	0.000000	59.00
60.00 06000 LABORATORY	0	0	0	74,035,061	0.000000	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	15,107,608	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	12,418,291	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	7,492,813	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	3,232,699	0.000000	68.00
68.01 03040 AUDIOLOGY	0	0	0	1,081,226	0.000000	68.01
69.00 06900 ELECTROCARDIOLOGY	0	0	0	16,193,391	0.000000	69.00
69.01 03160 CARDIOPULMONARY	0	0	0	1,501,263	0.000000	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	2,071,333	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	25,756,594	0.000000	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	48,136,777	0.000000	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	1,075,493	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	14,931,542	0.000000	90.00
91.00 09100 EMERGENCY	0	291,731	291,731	71,098,098	0.004103	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	16,501,688	0.000000	92.00
200.00 Total (lines 50 through 199)	0	291,731	291,731	538,149,512		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0289 Component CCN: 14-T289	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/30/2019 11:39 am
Title XVIII		Subprovider - IRF	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	62,062	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	10,450	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	148,046	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0.000000	7,135	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	101,110	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	38,277	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	28,364	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	548,201	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	156,759	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	1,899,819	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	1,886,667	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	295,982	0	0	0	68.00
68.01	03040 AUDIOLOGY	0.000000	0	0	0	0	68.01
69.00	06900 ELECTROCARDIOLOGY	0.000000	21,425	0	0	0	69.00
69.01	03160 CARDIOPULMONARY	0.000000	0	0	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	654	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	112,114	0	0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	561,961	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	51,124	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.004103	24,478	100	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	63,245	0	0	0	92.00
200.00	Total (lines 50 through 199)		6,017,873	100	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0289	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/30/2019 11:39 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		26,223	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		26,223	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)		21,740	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)		8,378	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		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)		20,219,025	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)		20,219,025	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)		20,219,025	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)		771.04	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		6,459,773	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)		6,459,773	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0289	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/30/2019 11:39 am		
Cost Center Description			Title XVIII		Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	4,400,974	2,379	1,849.93	815	1,507,693	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)					10,719,736	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					18,687,202	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)					426,146	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					718,235	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,144,381	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					17,542,821	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)					4,483	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					771.04	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,456,572	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0289		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/30/2019 11:39 am	
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	1,077,846	20,219,025	0.053309	3,456,572	184,266	90.00
91.00	Nursing School cost	0	20,219,025	0.000000	3,456,572	0	91.00
92.00	Allied health cost	0	20,219,025	0.000000	3,456,572	0	92.00
93.00	All other Medical Education	0	20,219,025	0.000000	3,456,572	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0289 Component CCN: 14-T289	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/30/2019 11:39 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,121	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,121	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		4,121	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)		2,783	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)		3,186,495	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)		3,186,495	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)		3,186,495	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)		773.23	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,151,899	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)		2,151,899	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0289 Component CCN: 14-T289		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/30/2019 11:39 am	
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)					1,520,044	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,671,943	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)					102,554	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					108,468	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					211,022	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,460,921	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: 14-0289 Component CCN: 14-T289		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/30/2019 11:39 am	
		Title XVIII		Subprovider - IRF		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	151,846	3,186,495	0.047653	0	0	90.00
91.00	Nursing School cost	0	3,186,495	0.000000	0	0	91.00
92.00	Allied health cost	0	3,186,495	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,186,495	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0289	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/30/2019 11:39 am	
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		10,905,777	30.00
31.00	03100	INTENSIVE CARE UNIT		2,042,732	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.164574	5,833,560	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.289042	7,645	52.00
53.00	05300	ANESTHESIOLOGY	0.032314	911,809	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.145345	3,676,714	54.00
56.00	05600	RADIOISOTOPE	0.097329	472,327	56.00
57.00	05700	CT SCAN	0.038627	5,586,339	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.073012	894,594	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.192435	1,538,503	59.00
60.00	06000	LABORATORY	0.104209	12,058,122	60.00
65.00	06500	RESPIRATORY THERAPY	0.161942	4,326,121	65.00
66.00	06600	PHYSICAL THERAPY	0.258442	1,716,203	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.289827	931,185	67.00
68.00	06800	SPEECH PATHOLOGY	0.463006	248,012	68.00
68.01	03040	AUDIOLOGY	0.147713	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.067831	2,886,803	69.00
69.01	03160	CARDIOPULMONARY	0.737029	305	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.045784	27,479	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.581748	4,927,613	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.207378	6,010,344	73.00
74.00	07400	RENAL DIALYSIS	0.342091	544,809	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.727231	22,599	90.00
91.00	09100	EMERGENCY	0.154724	5,731,339	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.209468	1,838,760	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		60,191,185	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)		60,191,185	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0289 Component CCN: 14-T289	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/30/2019 11:39 am
		Title XVIII	Subprovider - IRF	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
41.00	04100 SUBPROVIDER - IRF		4,579,964	41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.164574	62,062	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.289042	0	52.00
53.00	05300 ANESTHESIOLOGY	0.032314	10,450	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.145345	148,046	54.00
56.00	05600 RADIOISOTOPE	0.097329	7,135	56.00
57.00	05700 CT SCAN	0.038627	101,110	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.073012	38,277	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.192435	28,364	59.00
60.00	06000 LABORATORY	0.104209	548,201	60.00
65.00	06500 RESPIRATORY THERAPY	0.161942	156,759	65.00
66.00	06600 PHYSICAL THERAPY	0.258442	1,899,819	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.289827	1,886,667	67.00
68.00	06800 SPEECH PATHOLOGY	0.463006	295,982	68.00
68.01	03040 AUDIOLOGY	0.147713	0	68.01
69.00	06900 ELECTROCARDIOLOGY	0.067831	21,425	69.00
69.01	03160 CARDIOPULMONARY	0.737029	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.045784	654	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.581748	112,114	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.207378	561,961	73.00
74.00	07400 RENAL DIALYSIS	0.342091	51,124	74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.727231	0	90.00
91.00	09100 EMERGENCY	0.154724	24,478	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.209468	63,245	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		6,017,873	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)		6,017,873	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0289	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/30/2019 11:39 am
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		16,331,812	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)		150,141	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)		117.72	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		1.94	30.00
31.00	Percentage of Medicaid patient days (see instructions)		18.50	31.00
32.00	Sum of lines 30 and 31		20.44	32.00
33.00	Allowable disproportionate share percentage (see instructions)		6.08	33.00
34.00	Disproportionate share adjustment (see instructions)		248,244	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0289	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/30/2019 11:39 am
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		0	0 35.00
35.01	Factor 3 (see instructions)		0.000000000	0.000000000 35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		809,112	1,028,405 35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		605,171	259,215 35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		864,386	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 and 685. (see instructions)		0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 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 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	46.00
47.00	Subtotal (see instructions)		17,594,583	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)		17,594,583	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,384,170	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		29,435	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		23,516	58.00
59.00	Total (sum of amounts on lines 49 through 58)		19,031,704	59.00
60.00	Primary payer payments		32,394	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		18,999,310	61.00
62.00	Deductibles billed to program beneficiaries		2,093,916	62.00
63.00	Coinurance billed to program beneficiaries		42,210	63.00
64.00	Allowable bad debts (see instructions)		399,112	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		259,423	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		346,283	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		17,122,607	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-72,201	70.93
70.94	HRR adjustment amount (see instructions)		-24,118	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0289	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/30/2019 11:39 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		17,026,288	71.00
71.01	Sequestration adjustment (see instructions)		340,526	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		16,745,868	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)		-60,106	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		405,793	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
			Prior to 10/1	On/After 10/1
			1.00	2.00
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0289

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/30/2019 11:39 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0	0	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	16,331,812	0	0	16,331,812	16,331,812	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	150,141	0	0	150,141	150,141	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	0.000000	5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	0.000000	7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0608	0.0608	0.0608	0.0608	0.0608	10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	248,244	0	0	248,244	248,244	11.00
11.01	Uncompensated care payments	36.00	864,386	0	605,173	259,214	864,387	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	17,594,583	0	605,173	16,989,410	17,594,583	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	17,594,583	0	605,173	16,989,410	17,594,583	15.00
16.00	Payment for inpatient program capital (From Wkst. L, Pt. I, if applicable)	50.00	1,384,170	0	0	1,384,170	1,384,170	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ acquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0289

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/30/2019 11:39 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	605,173	18,373,580	18,978,753	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,319,765	0	0	1,319,765	1,319,765	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	8,579	0	0	8,579	8,579	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0423	0.0423	0.0423	0.0423		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	55,826	0	0	55,826	55,826	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,384,170	0	0	1,384,170	1,384,170	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

		Title XVIII			Hospital	PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A	Period to 10/01	Period on after 10/01	Total (col. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	16,331,812	0	0	0	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	150,141	0	0	0	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0608	0.0608	0.0608		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	248,244	248,244	0	248,244	11.00
11.01	Uncompensated care payments	36.00	864,386	605,171	259,215	864,386	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	17,594,583	17,335,368	259,215	17,594,583	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	17,594,583	17,335,368	259,215	17,594,583	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,384,170	1,035,284	348,886	1,384,170	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			18,370,652	608,101	18,978,753	19.00

		Title XVIII			Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)					
		0	1.00	2.00	3.00	4.00		
20.00	Capital DRG other than outlier	1.00	1,319,765	987,112	332,653	1,319,765	20.00	
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01	
21.00	Capital DRG outlier payments	2.00	8,579	6,417	2,162	8,579	21.00	
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01	
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00	
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0423	0.0423	0.0423		24.00	
25.00	Disproportionate share adjustment (see instructions)	11.00	55,826	41,755	14,071	55,826	25.00	
26.00	Total prospective capital payments (see instructions)	12.00	1,384,170	1,035,284	348,886	1,384,170	26.00	
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)					
		0	1.00	2.00	3.00	4.00		
27.00							27.00	
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00	
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00	
30.00	HVBP payment adjustment (see instructions)	70.93	-72,201	-54,002	-18,199	-72,201	30.00	
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01	
31.00	HRR adjustment (see instructions)	70.94	-24,118	-18,039	-6,079	-24,118	31.00	
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01	
						(Amt. to Wkst. E, Pt. A)		
		0	1.00	2.00	3.00	4.00		
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00	
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0289	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/30/2019 11:39 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		2,226	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		15,749,397	2.00
3.00	OPPS payments		13,433,070	3.00
4.00	Outlier payment (see instructions)		6,883	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		36,890	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		2,226	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		10,735	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)		10,735	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		10,735	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		8,509	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)		2,226	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)		13,476,843	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,569,929	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)		10,909,140	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)		10,909,140	30.00
31.00	Primary payer payments		7,876	31.00
32.00	Subtotal (line 30 minus line 31)		10,901,264	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)		325,733	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		211,726	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		285,836	36.00
37.00	Subtotal (see instructions)		11,112,990	37.00
38.00	MSP-LCC reconciliation amount from PS&R		1,139	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		11,111,851	40.00
40.01	Sequestration adjustment (see instructions)		222,237	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		10,848,432	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		41,182	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: 14-0289

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

Worksheet E-1
Part I
Date/Time Prepared:
5/30/2019 11:39 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		16,745,868		10,820,483	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	08/06/2018	27,949	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		27,949	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)		16,745,868		10,848,432	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		41,182	6.01	
6.02	SETTLEMENT TO PROGRAM		60,106		0	6.02	
7.00	Total Medicare program liability (see instructions)		16,685,762		10,889,614	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: 14-0289
Component CCN: 14-T289

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

Worksheet E-1
Part I
Date/Time Prepared:
5/30/2019 11:39 am

Title XVIII

Subprovider -
IRF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		4,628,948		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,628,948		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		9,412		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,638,360		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: 14-0289	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/30/2019 11:39 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0289 Component CCN: 14-T289	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part III Date/Time Prepared: 5/30/2019 11:39 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			4,632,316 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0131 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			178,344 3.00
4.00	Outlier Payments			21,387 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	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 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			11.290411 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			4,832,047 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			4,832,047 17.00
18.00	Primary payer payments			28,059 18.00
19.00	Subtotal (line 17 less line 18).			4,803,988 19.00
20.00	Deductibles			72,336 20.00
21.00	Subtotal (line 19 minus line 20)			4,731,652 21.00
22.00	Coinsurance			9,045 22.00
23.00	Subtotal (line 21 minus line 22)			4,722,607 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			15,866 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			10,313 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			14,550 26.00
27.00	Subtotal (sum of lines 23 and 25)			4,732,920 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			100 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			4,733,020 32.00
32.01	Sequestration adjustment (see instructions)			94,660 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			4,628,948 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			9,412 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			21,387 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: 14-0289

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

Worksheet G

Date/Time Prepared:
5/30/2019 11:39 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	3,996,068	0	0	0	1.00
2.00	Temporary investments	-713,612	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	18,371,009	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,945,499	0	0	0	7.00
8.00	Prepaid expenses	2,171,080	0	0	0	8.00
9.00	Other current assets	7,256,201	0	0	0	9.00
10.00	Due from other funds	176,663	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	34,202,908	0	0	0	11.00
FIXED ASSETS						
12.00	Land	963,454	0	0	0	12.00
13.00	Land improvements	3,151,148	0	0	0	13.00
14.00	Accumulated depreciation	-2,503,978	0	0	0	14.00
15.00	Buildings	111,998,495	0	0	0	15.00
16.00	Accumulated depreciation	-47,432,360	0	0	0	16.00
17.00	Leasehold improvements	24,000	0	0	0	17.00
18.00	Accumulated depreciation	-24,000	0	0	0	18.00
19.00	Fixed equipment	5,579,800	0	0	0	19.00
20.00	Accumulated depreciation	-4,062,689	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	42,340,910	0	0	0	23.00
24.00	Accumulated depreciation	-31,937,383	0	0	0	24.00
25.00	Minor equipment depreciable	83,185	0	0	0	25.00
26.00	Accumulated depreciation	-83,185	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	6,478,521	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	84,575,918	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	104,956,820	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	6,109,597	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	111,066,417	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	229,845,243	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	6,030,868	0	0	0	37.00
38.00	Salaries, wages, and fees payable	7,194,825	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	6,113,124	0	0	0	43.00
44.00	Other current liabilities	7,848,253	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	27,187,070	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	29,744,448	0	0	0	46.00
47.00	Notes payable	2,677,222	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	16,261,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	48,682,670	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	75,869,740	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	153,975,503				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)	153,975,503	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	229,845,243	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0289

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

Worksheet G-1

Date/Time Prepared:
5/30/2019 11:39 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		154,796,294		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		9,428,704			2.00
3.00	Total (sum of line 1 and line 2)		164,224,998		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		164,224,998		0	11.00
12.00	TRANSFERS	10,249,495		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		10,249,495		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		153,975,503		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	TRANSFERS		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0289

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/30/2019 11:39 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	33,329,820		33,329,820	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	6,803,767		6,803,767	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)	40,133,587		40,133,587	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,508,200		5,508,200	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)	5,508,200		5,508,200	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	45,641,787		45,641,787	17.00
18.00	Ancillary services	131,976,553	303,641,631	435,618,184	18.00
19.00	Outpatient services	17,355,668	85,175,660	102,531,328	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,305,262	1,305,262	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)	194,974,008	390,122,553	585,096,561	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		140,210,104		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)		140,210,104		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0289

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

Worksheet G-3

Date/Time Prepared:
5/30/2019 11:39 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	585,096,561	1.00
2.00	Less contractual allowances and discounts on patients' accounts	432,605,052	2.00
3.00	Net patient revenues (line 1 minus line 2)	152,491,509	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	140,210,104	4.00
5.00	Net income from service to patients (line 3 minus line 4)	12,281,405	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	-4,955,210	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	103,486	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	1,070,798	22.00
23.00	Governmental appropriations	0	23.00
24.00	MANAGEMENT FEES	180,000	24.00
24.01	SISHA INCOME	133,804	24.01
24.02	MISC INCOME	816,056	24.02
25.00	Total other income (sum of lines 6-24)	-2,651,066	25.00
26.00	Total (line 5 plus line 25)	9,630,339	26.00
27.00	LOSS ON DISPOSAL OF INCOME	201,635	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	201,635	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	9,428,704	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0289

Period: From 01/01/2018

Worksheet H

HHA CCN: 14-7420

To 12/31/2018

Date/Time Prepared: 5/30/2019 11:39 am

Home Health Agency I

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	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures		0		0	0	1.00
2.00	Capital Related - Movable Equipment		0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	169,939	0	435	10,466	180,840	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	477,112	0	19,789	0	496,901	6.00
7.00	Physical Therapy	221,561	0	17,319	22,347	261,227	7.00
8.00	Occupational Therapy	82,892	0	7,131	0	90,023	8.00
9.00	Speech Pathology	18,711	0	1,846	0	20,557	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	51,149	0	2,698	0	53,847	11.00
12.00	Supplies (see instructions)	0	0	0	13,424	13,424	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Tel emedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,021,364	0	48,783	22,782	1,116,819	24.00
	Reclassified	Reclassified	Adjustments	Net Expenses			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0	0	1.00
2.00	Capital Related - Movable Equipment	0	0	0	0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	-1,430	179,410	0	179,410	0	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	496,901	0	496,901	0	6.00
7.00	Physical Therapy	0	261,227	0	261,227	0	7.00
8.00	Occupational Therapy	0	90,023	0	90,023	0	8.00
9.00	Speech Pathology	0	20,557	0	20,557	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	53,847	0	53,847	0	11.00
12.00	Supplies (see instructions)	-7,022	6,402	0	6,402	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Tel emedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	-8,452	1,108,367	0	1,108,367	0	24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 14-0289 HHA CCN: 14-7420		Period: From 01/01/2018 To 12/31/2018		Worksheet H-1 Part I Date/Time Prepared: 5/30/2019 11:39 am	
				Home Health Agency I		PPS	
	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		Bldgs & Fixtures	Movable Equipment				
		1.00	2.00				
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00
2.00	Capital Related - Movable Equipment	0	0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	179,410	0	0	0	179,410	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	496,901	0	0	0	496,901	6.00
7.00	Physical Therapy	261,227	0	0	0	261,227	7.00
8.00	Occupational Therapy	90,023	0	0	0	90,023	8.00
9.00	Speech Pathology	20,557	0	0	0	20,557	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	53,847	0	0	0	53,847	11.00
12.00	Supplies (see instructions)	6,402	0	0	0	6,402	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,108,367	0	0	0	1,108,367	24.00
		Administrative & General	Total (cols. 4A + 5)				
		5.00	6.00				
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures						1.00
2.00	Capital Related - Movable Equipment						2.00
3.00	Plant Operation & Maintenance						3.00
4.00	Transportation						4.00
5.00	Administrative and General	179,410					5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	95,967	592,868				6.00
7.00	Physical Therapy	50,451	311,678				7.00
8.00	Occupational Therapy	17,386	107,409				8.00
9.00	Speech Pathology	3,970	24,527				9.00
10.00	Medical Social Services	0	0				10.00
11.00	Home Health Aide	10,400	64,247				11.00
12.00	Supplies (see instructions)	1,236	7,638				12.00
13.00	Drugs	0	0				13.00
14.00	DME	0	0				14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0				15.00
16.00	Respiratory Therapy	0	0				16.00
17.00	Private Duty Nursing	0	0				17.00
18.00	Clinic	0	0				18.00
19.00	Health Promotion Activities	0	0				19.00
20.00	Day Care Program	0	0				20.00
21.00	Home Delivered Meals Program	0	0				21.00
22.00	Homemaker Service	0	0				22.00
23.00	All Others (specify)	0	0				23.00
23.50	Telemedicine	0	0				23.50
24.00	Total (sum of lines 1-23)		1,108,367				24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-0289

Period: From 01/01/2018

Worksheet H-1

HHA CCN: 14-7420

To 12/31/2018

Part II
Date/Time Prepared:
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	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-179,410	928,957
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	496,901
7.00	Physical Therapy	0	0	0	0	0	261,227
8.00	Occupational Therapy	0	0	0	0	0	90,023
9.00	Speech Pathology	0	0	0	0	0	20,557
10.00	Medical Social Services	0	0	0	0	0	0
11.00	Home Health Aide	0	0	0	0	0	53,847
12.00	Supplies (see instructions)	0	0	0	0	0	6,402
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
23.50	Telemedicine	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	0	-179,410	928,957
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		179,410
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.193131

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0289

Period: From 01/01/2018

Worksheet H-2

HHA CCN: 14-7420

To 12/31/2018

Part I
Date/Time Prepared: 5/30/2019 11:39 am

Home Health Agency I

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Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		BLDG & FIXT	MVBLE EQUIP					
		1.00	2.00	4.00				
	0	8,944	0	40,980	49,924	11,625	1.00	
1.00 Administrative and General	0	8,944	0	40,980	49,924	11,625	1.00	
2.00 Skilled Nursing Care	592,868	0	0	115,054	707,922	164,849	2.00	
3.00 Physical Therapy	311,678	0	0	53,428	365,106	85,020	3.00	
4.00 Occupational Therapy	107,409	0	0	19,989	127,398	29,666	4.00	
5.00 Speech Pathology	24,527	0	0	4,512	29,039	6,762	5.00	
6.00 Medical Social Services	0	0	0	0	0	0	6.00	
7.00 Home Health Aide	64,247	0	0	12,334	76,581	17,833	7.00	
8.00 Supplies (see instructions)	7,638	0	0	0	7,638	1,779	8.00	
9.00 Drugs	0	0	0	0	0	0	9.00	
10.00 DME	0	0	0	0	0	0	10.00	
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00 Clinic	0	0	0	0	0	0	14.00	
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00 Day Care Program	0	0	0	0	0	0	16.00	
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00 Homemaker Service	0	0	0	0	0	0	18.00	
19.00 All Others (specify)	0	0	0	0	0	0	19.00	
19.50 Telemedicine	0	0	0	0	0	0	19.50	
20.00 Total (sum of lines 1-19) (2)	1,108,367	8,944	0	246,297	1,363,608	317,534	20.00	
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00	
Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA		
	6.00	7.00	8.00	9.00	10.00	11.00		
1.00 Administrative and General	9,744	9,352	0	0	0	0	1.00	
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00	
3.00 Physical Therapy	0	0	0	0	0	0	3.00	
4.00 Occupational Therapy	0	0	0	0	0	0	4.00	
5.00 Speech Pathology	0	0	0	0	0	0	5.00	
6.00 Medical Social Services	0	0	0	0	0	0	6.00	
7.00 Home Health Aide	0	0	0	0	0	0	7.00	
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00	
9.00 Drugs	0	0	0	0	0	0	9.00	
10.00 DME	0	0	0	0	0	0	10.00	
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00 Clinic	0	0	0	0	0	0	14.00	
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00 Day Care Program	0	0	0	0	0	0	16.00	
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00 Homemaker Service	0	0	0	0	0	0	18.00	
19.00 All Others (specify)	0	0	0	0	0	0	19.00	
19.50 Telemedicine	0	0	0	0	0	0	19.50	
20.00 Total (sum of lines 1-19) (2)	9,744	9,352	0	0	0	0	20.00	
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00	

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0289

Period: From 01/01/2018

Worksheet H-2

HHA CCN: 14-7420

To 12/31/2018

Part I
Date/Time Prepared:
5/30/2019 11:39 am

Home Health Agency I

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Cost Center Description		NURSING	CENTRAL	PHARMACY	MEDICAL	SOCIAL SERVICE	PARAMEDICAL	
		ADMINISTRATION	SERVICES & SUPPLY		RECORDS & LIBRARY		EDUCATION PRGM	
		13.00	14.00	15.00	16.00	17.00	23.00	
1.00	Administrative and General	0	665	0	4,829	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	665	0	4,829	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs		
		24.00	25.00	26.00	27.00	28.00		
1.00	Administrative and General	86,139	0	86,139				1.00
2.00	Skilled Nursing Care	872,771	0	872,771	46,418	919,189		2.00
3.00	Physical Therapy	450,126	0	450,126	23,940	474,066		3.00
4.00	Occupational Therapy	157,064	0	157,064	8,354	165,418		4.00
5.00	Speech Pathology	35,801	0	35,801	1,904	37,705		5.00
6.00	Medical Social Services	0	0	0	0	0		6.00
7.00	Home Health Aide	94,414	0	94,414	5,022	99,436		7.00
8.00	Supplies (see instructions)	9,417	0	9,417	501	9,918		8.00
9.00	Drugs	0	0	0	0	0		9.00
10.00	DME	0	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0	0		13.00
14.00	Clinic	0	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0	0		18.00
19.00	All Others (specify)	0	0	0	0	0		19.00
19.50	Telemedicine	0	0	0	0	0		19.50
20.00	Total (sum of lines 1-19) (2)	1,705,732	0	1,705,732	86,139	1,705,732		20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.053186			21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0289
HHA CCN: 14-7420

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

Worksheet H-2
Part II
Date/Time Prepared:
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Home Health
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00					
1.00 Administrative and General	919	0	169,939	0	49,924	919	1.00
2.00 Skilled Nursing Care	0	0	477,112	0	707,922	0	2.00
3.00 Physical Therapy	0	0	221,561	0	365,106	0	3.00
4.00 Occupational Therapy	0	0	82,892	0	127,398	0	4.00
5.00 Speech Pathology	0	0	18,711	0	29,039	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	51,149	0	76,581	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	7,638	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	919	0	1,021,364		1,363,608	919	20.00
21.00 Total cost to be allocated	8,944	0	246,297		317,534	9,744	21.00
22.00 Unit cost multiplier	9.732318	0.000000	0.241145		0.232863	10.602829	22.00
Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
	7.00	8.00	9.00	10.00	11.00	13.00	
1.00 Administrative and General	919	0	0	0	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	919	0	0	0	0	0	20.00
21.00 Total cost to be allocated	9,352	0	0	0	0	0	21.00
22.00 Unit cost multiplier	10.176279	0.000000	0.000000	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0289
HHA CCN: 14-7420

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

Worksheet H-2
Part II
Date/Time Prepared:
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Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	PARAMEDICAL EDUCATION PRGM (ASSIGNED TIME)		
	14.00	15.00	16.00	17.00	23.00		
1.00 Administrative and General	5,320	0	102	0	0		1.00
2.00 Skilled Nursing Care	0	0	0	0	0		2.00
3.00 Physical Therapy	0	0	0	0	0		3.00
4.00 Occupational Therapy	0	0	0	0	0		4.00
5.00 Speech Pathology	0	0	0	0	0		5.00
6.00 Medical Social Services	0	0	0	0	0		6.00
7.00 Home Health Aide	0	0	0	0	0		7.00
8.00 Supplies (see instructions)	0	0	0	0	0		8.00
9.00 Drugs	0	0	0	0	0		9.00
10.00 DME	0	0	0	0	0		10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0		11.00
12.00 Respiratory Therapy	0	0	0	0	0		12.00
13.00 Private Duty Nursing	0	0	0	0	0		13.00
14.00 Clinic	0	0	0	0	0		14.00
15.00 Health Promotion Activities	0	0	0	0	0		15.00
16.00 Day Care Program	0	0	0	0	0		16.00
17.00 Home Delivered Meals Program	0	0	0	0	0		17.00
18.00 Homemaker Service	0	0	0	0	0		18.00
19.00 All Others (specify)	0	0	0	0	0		19.00
19.50 Telemedicine	0	0	0	0	0		19.50
20.00 Total (sum of lines 1-19)	5,320	0	102	0	0		20.00
21.00 Total cost to be allocated	665	0	4,829	0	0		21.00
22.00 Unit cost multiplier	0.125000	0.000000	47.343137	0.000000	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 14-0289 HHA CCN: 14-7420	Period: From 01/01/2018 To 12/31/2018	Worksheet H-3 Part I Date/Time Prepared: 5/30/2019 11:39 am
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		Title XVIII		Home Health Agency I		PPS	
Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (col. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 + col. 4)	
	0	1.00	2.00	3.00	4.00	5.00	

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	919,189		919,189	3,205	286.80	1.00
2.00	Physical Therapy	3.00	474,066	0	474,066	2,805	169.01	2.00
3.00	Occupational Therapy	4.00	165,418	0	165,418	1,155	143.22	3.00
4.00	Speech Pathology	5.00	37,705	0	37,705	299	126.10	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	99,436		99,436	437	227.54	6.00
7.00	Total (sum of lines 1-6)		1,695,814	0	1,695,814	7,901		7.00

Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits		Ratio (col. 3 + col. 4)
				Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
	0	1.00	2.00	3.00	4.00	5.00

Limitation Cost Computation							
8.00	Skilled Nursing Care		41180	0	1,293		8.00
9.00	Physical Therapy		41180	0	1,143		9.00
10.00	Occupational Therapy		41180	0	421		10.00
11.00	Speech Pathology		41180	0	104		11.00
12.00	Medical Social Services		41180	0	0		12.00
13.00	Home Health Aide		41180	0	218		13.00
14.00	Total (sum of lines 8-13)			0	3,179		14.00

Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (col. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 + col. 4)
	0	1.00	2.00	3.00	4.00	5.00

Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	9,918	0	9,918	10,785	0.919611	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

Cost Center Description	Part A	Program Visits		Cost of Services	Part B	Ratio (col. 3 + col. 4)
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			
	6.00	7.00	8.00	9.00	10.00	11.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,293		0	370,832	1.00
2.00	Physical Therapy	0	1,143		0	193,178	2.00
3.00	Occupational Therapy	0	421		0	60,296	3.00
4.00	Speech Pathology	0	104		0	13,114	4.00
5.00	Medical Social Services	0	0		0	0	5.00
6.00	Home Health Aide	0	218		0	49,604	6.00
7.00	Total (sum of lines 1-6)	0	3,179		0	687,024	7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0289
HHA CCN: 14-7420

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

Worksheet H-3
Part I
Date/Time Prepared:
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Cost Center Description	Program Covered Charges			Cost of Services				
	Part A	Part B						
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
	6.00	7.00	8.00	9.00	10.00	11.00		
Supplies and Drugs Cost Computations								
15.00 Cost of Medical Supplies	0	10,785	0	0	9,918	0	15.00	
16.00 Cost of Drugs		0	0		0	0	16.00	
Cost Center Description	Total Program Cost (sum of col.s. 9-10)							
	12.00							
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00 Skilled Nursing Care	370,832							1.00
2.00 Physical Therapy	193,178							2.00
3.00 Occupational Therapy	60,296							3.00
4.00 Speech Pathology	13,114							4.00
5.00 Medical Social Services	0							5.00
6.00 Home Health Aide	49,604							6.00
7.00 Total (sum of lines 1-6)	687,024							7.00
Cost Center Description								
	12.00							
Limitation Cost Computation								
8.00 Skilled Nursing Care								8.00
9.00 Physical Therapy								9.00
10.00 Occupational Therapy								10.00
11.00 Speech Pathology								11.00
12.00 Medical Social Services								12.00
13.00 Home Health Aide								13.00
14.00 Total (sum of lines 8-13)								14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0289
HHA CCN: 14-7420

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

Worksheet H-3
Part II
Date/Time Prepared:
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Title XVIII

Home Health
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PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.258442	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.289827	0	0	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.463006	0	0	col. 2, line 4.00		3.00
3.01 Speech Pathology 1	68.01	0.147713	0	0	col. 2, line 4.01		3.01
4.00 Cost of Medical Supplies	71.00	0.581748	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.207378	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0289 HHA CCN: 14-7420	Period: From 01/01/2018 To 12/31/2018	Worksheet H-4 Part I-II Date/Time Prepared: 5/30/2019 11:39 am
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	594,391
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	3,872
13.00	Total PPS Reimbursement - LUPA Episodes		0	24,744
14.00	Total PPS Reimbursement - PEP Episodes		0	6,302
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	1,162
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	69
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	630,540
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	630,540
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	630,540
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	630,540
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
30.99	Demonstration payment adjustment amount before sequestration		0	0
31.00	Subtotal (see instructions)		0	630,540
31.01	Sequestration adjustment (see instructions)		0	12,610
31.02	Demonstration payment adjustment amount after sequestration		0	0
32.00	Interim payments (see instructions)		0	617,929
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	1
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

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

Provider CCN: 14-0289
HHA CCN: 14-7420

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

Worksheet H-5
Date/Time Prepared:
5/30/2019 11:39 am
PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		617,929	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		617,929	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		1	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		617,930	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
				0	1.00	2.00
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0289	Period: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III Date/Time Prepared: 5/30/2019 11:39 am
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,319,765	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		8,579	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)		67.49	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)		1.94	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		18.50	8.00
9.00	Sum of lines 7 and 8		20.44	9.00
10.00	Allowable disproportionate share percentage (see instructions)		4.23	10.00
11.00	Disproportionate share adjustment (see instructions)		55,826	11.00
12.00	Total prospective capital payments (see instructions)		1,384,170	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