

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: 14-0012	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/30/2019 2:58 pm
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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: 2:58 pm
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 KATHERINE SHAW BETHEA (14-0012) 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	-23,374	5,309	0	0	1.00
2.00 Subprovider - IPF	0	45	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0	0	0		0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00 Total	0	-23,329	5,309	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: 14-0012		Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part I Date/Time Prepared: 5/30/2019 2:58 pm					
1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box: 403 EAST State: IL		3.00 Zip Code: 61021		4.00 County: LEE					
1.00 Street: KATHERINE SHAW BETHEA HOSPITAL		2.00 City: DIXON									
Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)					
1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00			
3.00 Hospital and Hospital-Based Component Identification:											
3.00	Hospital	KATHERINE SHAW BETHEA	140012	99914	1	07/01/1966	N	P	0	3.00	
4.00	Subprovider - IPF	KSB PSYCH	14S012	99914	4	11/01/1983	N	P	0	4.00	
5.00	Subprovider - IRF									5.00	
6.00	Subprovider - (Other)									6.00	
7.00	Swing Beds - SNF									7.00	
8.00	Swing Beds - NF									8.00	
9.00	Hospital-Based SNF									9.00	
10.00	Hospital-Based NF									10.00	
11.00	Hospital-Based OLTG									11.00	
12.00	Hospital-Based HHA	KSB HOME HEALTH	147131	99914		07/07/1976	N	P	N	12.00	
13.00	Separately Certified ASC									13.00	
14.00	Hospital-Based Hospice									14.00	
15.00	Hospital-Based Health Clinic - RHC									15.00	
16.00	Hospital-Based Health Clinic - FQHC									16.00	
17.00	Hospital-Based (CMHC) I									17.00	
18.00	Renal Dialysis									18.00	
19.00	Other									19.00	
						From:	To:				
						1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2018	12/31/2018		20.00		
21.00	Type of Control (see instructions)					2			21.00		
						1.00	2.00	3.00			
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				Y	N			22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				Y	Y			22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.				N	N			22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				N	N			22.03		
23.00	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			23.00		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.				1	N			23.00		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days				
		1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.				499	231	0	0	813	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0012		Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part I Date/Time Prepared: 5/30/2019 2:58 pm			
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0	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.					2		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.					2		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00	
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					Y	Y	40.00	
						V	XVII	XIX	
						1.00	2.00	3.00	
<u>Prospective Payment System (PPS)-Capital</u>									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
<u>Teaching Hospitals</u>									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					Y			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)					N		60.00	

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

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				1.00		
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00	
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00	
			V	XIX		
			1.00	2.00		
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.06	
Rural Providers						
105.00	Does this hospital qualify as a CAH?		N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		N		106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.		N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00	
			Physical	Occupational	Speech	Respiratory
			1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N	N	N
				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: 14-0012	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/30/2019 2:58 pm		
		1.00	2.00			
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00
		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	776,004	460,504			0118.01
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0012	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/30/2019 2:58 pm			
1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	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.				N	145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N	146.00	
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.				N	147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.				N	148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				N	149.00	
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
				1.00			
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)				0	168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)				9.99	169.00	
		Beginning	Ending				
		1.00	2.00				
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			10/01/2017	12/31/2017	170.00	
		1.00	2.00				
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)				N	0	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0012		Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part II Date/Time Prepared: 5/30/2019 2:58 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		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	03/25/2019			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y					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.	Y					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	03/05/2019	Y	03/05/2019		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: 14-0012	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/30/2019 2:58 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N	N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00		2.00	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN		WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4446		KEVIN.WELLEN@CLACONNECT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0012	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/30/2019 2:58 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DI RECTOR, REIMBURSEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0012

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

Worksheet S-3
Part I
Date/Time Prepared:
5/30/2019 2:58 pm

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	60	21,900	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)		60	21,900	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	6	2,190	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)		66	24,090	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	14	5,110		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	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)		80				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: 14-0012

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

Worksheet S-3
Part I
Date/Time Prepared:
5/30/2019 2:58 pm

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)	3,356	722	6,344			1.00
2.00 HMO and other (see instructions)	632	572				2.00
3.00 HMO IPF Subprovider	20	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	3,356	722	6,344			7.00
8.00 INTENSIVE CARE UNIT	512	95	1,508			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		154	557			13.00
14.00 Total (see instructions)	3,868	971	8,409	4.22	751.40	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	491	820	2,015	0.00	19.76	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	927	384	5,835	0.00	11.39	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)				4.22	782.55	27.00
28.00 Observation Bed Days		453	2,070			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	48			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: 14-0012	Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part I Date/Time Prepared: 5/30/2019 2:58 pm
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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	1,166	434	2,556	1.00
2.00 HMO and other (see instructions)			195	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,166	434	2,556	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	119	275	598	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 14-0012		Period: From 01/01/2018 To 12/31/2018		Worksheet S-3 Part II Date/Time Prepared: 5/30/2019 2:58 pm	
	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	59,425,194	0	59,425,194	1,627,622.38	36.51	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		2,584,852	0	2,584,852	9,790.00	264.03	4.00
4.01	Physicians - Part A - Teaching		396,999	0	396,999	3,340.58	118.84	4.01
5.00	Physician and Non-Physician-Part B		17,810,777	0	17,810,777	102,467.34	173.82	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	301,391	301,391	11,682.00	25.80	7.00
7.01	Contracted interns and residents (in an approved programs)		609,006	0	609,006	16,640.00	36.60	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		1,982,380	19,040	2,001,420	64,810.41	30.88	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract Labor: Direct Patient Care		74,564	0	74,564	1,128.50	66.07	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract Labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		17,387,094	0	17,387,094			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		784,980	0	784,980			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		118,576	0	118,576			22.00
22.01	Physician Part A - Teaching		40,461	0	40,461			22.01
23.00	Physician Part B		1,241,079	0	1,241,079			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		141,492	0	141,492			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	1,029,047	-592,415	436,632	18,088.40	24.14	26.00
27.00	Administrative & General	5.00	7,816,274	224,794	8,041,068	285,765.06	28.14	27.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0012

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

Worksheet S-3
Part II
Date/Time Prepared:
5/30/2019 2:58 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)	176,178	0	176,178	821.36	214.50	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	845,299	22,150	867,449	37,893.15	22.89	30.00
31.00	Laundry & Linen Service	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	711,590	-126,421	585,169	50,229.39	11.65	32.00
33.00	Housekeeping under contract (see instructions)	0	0	0	0.00	0.00	33.00
34.00	Dietary	1,053,958	-830,967	222,991	13,104.20	17.02	34.00
35.00	Dietary under contract (see instructions)	0	0	0	0.00	0.00	35.00
36.00	Cafeteria	0	852,203	852,203	55,351.35	15.40	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	1,369,425	-216,997	1,152,428	30,128.57	38.25	38.00
39.00	Central Services and Supply	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	818,628	7,143	825,771	22,816.53	36.19	40.00
41.00	Medical Records & Medical Records Library	801,395	-51,828	749,567	36,319.78	20.64	41.00
42.00	Social Service	0	287,743	287,743	10,459.40	27.51	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0012

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

Worksheet S-3
Part III
Date/Time Prepared:
5/30/2019 2:58 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation 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)	40,784,590	-301,391	40,483,199	1,494,313.82	27.09	1.00
2.00	Excluded area salaries (see instructions)	1,982,380	19,040	2,001,420	64,810.41	30.88	2.00
3.00	Subtotal salaries (line 1 minus line 2)	38,802,210	-320,431	38,481,779	1,429,503.41	26.92	3.00
4.00	Subtotal other wages & related costs (see inst.)	74,564	0	74,564	1,128.50	66.07	4.00
5.00	Subtotal wage-related costs (see inst.)	17,505,670	0	17,505,670	0.00	45.49	5.00
6.00	Total (sum of lines 3 thru 5)	56,382,444	-320,431	56,062,013	1,430,631.91	39.19	6.00
7.00	Total overhead cost (see instructions)	14,621,794	-424,595	14,197,199	560,977.19	25.31	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0012	Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part IV Date/Time Prepared: 5/30/2019 2:58 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			2,232,673 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			13,868 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)			10,626,851 8.02
8.03	Health Insurance (Purchased)			0 8.03
9.00	Prescription Drug Plan			2,144,860 9.00
10.00	Dental, Hearing and Vision Plan			435,395 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			69,001 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)			189,516 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			89,741 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			3,557,788 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			30,062 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))			150,000 21.00
22.00	Day Care Cost and Allowances			70,704 22.00
23.00	Tuition Reimbursement			103,223 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			19,713,682 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: 14-0012	Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part V Date/Time Prepared: 5/30/2019 2:58 pm
Cost Center Description			Contract Labor	Benefit Cost
			1.00	2.00
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		74,564	19,713,682 1.00
2.00	Hospital		74,564	19,713,682 2.00
3.00	Subprovider - IPF		0	0 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			17.00
18.00	Other		0	0 18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 14-0012 Component CCN: 14-7131		Period: From 01/01/2018 To 12/31/2018		Worksheet S-4 Date/Time Prepared: 5/30/2019 2:58 pm	
				Home Health Agency I		PPS	
				1.00			
0.00	County			LEE		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	861	71	263	1,195	
2.00	Unduplicated Census Count (see instructions)	0.00	68.00	14.00	340.00	422.00	
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
				0	1.00	2.00	3.00
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		0.00	0.00	0.00	
4.00	Director(s) and Assistant Director(s)			1.00	0.00	1.00	
5.00	Other Administrative Personnel			1.87	0.00	1.87	
6.00	Direct Nursing Service			3.95	0.00	3.95	
7.00	Nursing Supervisor			1.37	0.00	1.37	
8.00	Physical Therapy Service			1.78	0.00	1.78	
9.00	Physical Therapy Supervisor			0.09	0.00	0.09	
10.00	Occupational Therapy Service			0.40	0.00	0.40	
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	
12.00	Speech Pathology Service			0.06	0.00	0.06	
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	
14.00	Medical Social Service			0.00	0.00	0.00	
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	
16.00	Home Health Aide			0.57	0.00	0.57	
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	
18.00	CLERK			0.30	0.00	0.30	
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			
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99914			
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers	3.00	4.00	5.00	
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	333	24	9	0	366	
22.00	Skilled Nursing Visit Charges	64,602	4,656	1,746	0	71,004	
23.00	Physical Therapy Visits	378	0	16	0	394	
24.00	Physical Therapy Visit Charges	73,332	0	3,104	0	76,436	
25.00	Occupational Therapy Visits	52	0	0	0	52	
26.00	Occupational Therapy Visit Charges	10,088	0	0	0	10,088	
27.00	Speech Pathology Visits	8	0	3	0	11	
28.00	Speech Pathology Visit Charges	1,552	0	582	0	2,134	
29.00	Medical Social Service Visits	1	0	0	0	1	
30.00	Medical Social Service Visit Charges	194	0	0	0	194	
31.00	Home Health Aide Visits	103	0	0	0	103	
32.00	Home Health Aide Visit Charges	7,210	0	0	0	7,210	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	875	24	28	0	927	
34.00	Other Charges	0	0	0	0	0	
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	156,978	4,656	5,432	0	167,066	
36.00	Total Number of Episodes (standard/non outlier)	64		9	0	73	
37.00	Total Number of Outlier Episodes		1		0	1	
38.00	Total Non-Routine Medical Supply Charges	14,786	213	1,055	0	16,054	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0012	Period: From 01/01/2018 To 12/31/2018	Worksheet S-10 Date/Time Prepared: 5/30/2019 2:58 pm
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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)		0.248285	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		2,364,725	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		2,143,887	5.00
6.00	Medicaid charges		41,754,121	6.00
7.00	Medicaid cost (line 1 times line 6)		10,366,922	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		5,858,310	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		31,123	9.00
10.00	Stand-alone CHIP charges		393,419	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		97,680	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		66,557	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		5,924,867	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)	2,902,940	0	2,902,940
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	720,756	0	720,756
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	720,756	0	720,756
			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)		11,404,685	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		129,729	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		199,583	27.01
28.00	Non-Medicare bad debt expense (see instructions)		11,205,102	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		2,851,913	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		3,572,669	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		9,497,536	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0012

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

Worksheet A
Date/Time Prepared: 5/30/2019 2:58 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (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		5,560,452	5,560,452	-718,883	4,841,569	1.00
2.00	00200		0	0	1,639,299	1,639,299	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	1,029,047	16,567,620	17,596,667	-502,674	17,093,993	4.00
5.01	00540	318,058	111,840	429,898	300,877	730,775	5.01
5.02	00590	846,412	3,855,137	4,701,549	-285,409	4,416,140	5.02
5.03	00591	348,811	816,736	1,165,547	19,932	1,185,479	5.03
5.04	00580	2,315,977	2,723,284	5,039,261	47,547	5,086,808	5.04
5.05	00592	3,987,016	9,274,945	13,261,961	-148,053	13,113,908	5.05
7.00	00700	845,299	2,749,706	3,595,005	-160,202	3,434,803	7.00
8.00	00800	0	297,023	297,023	0	297,023	8.00
9.00	00900	711,590	611,927	1,323,517	-137,426	1,186,091	9.00
10.00	01000	1,053,958	693,525	1,747,483	-1,391,733	355,750	10.00
11.00	01100	0	0	0	1,412,969	1,412,969	11.00
13.00	01300	1,369,425	568,189	1,937,614	-234,855	1,702,759	13.00
14.00	01400	0	3,794,928	3,794,928	-3,734,392	60,536	14.00
15.00	01500	818,628	3,707,362	4,525,990	-1,971,880	2,554,110	15.00
16.00	01600	801,395	1,667,169	2,468,564	-62,393	2,406,171	16.00
17.00	01700	0	0	0	79,749	79,749	17.00
17.01	01701	0	0	0	229,747	229,747	17.01
21.00	02100	0	0	0	933,192	933,192	21.00
22.00	02200	0	0	0	481,497	481,497	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	3,502,374	935,976	4,438,350	-149,955	4,288,395	30.00
31.00	03100	973,427	398,019	1,371,446	12,037	1,383,483	31.00
40.00	04000	1,049,352	607,142	1,656,494	12,089	1,668,583	40.00
43.00	04300	442,790	74,904	517,694	5,252	522,946	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	2,042,739	1,444,229	3,486,968	-188,014	3,298,954	50.00
52.00	05200	0	0	0	190,524	190,524	52.00
53.00	05300	0	1,120,773	1,120,773	-21,182	1,099,591	53.00
54.00	05400	1,272,465	1,009,238	2,281,703	18,583	2,300,286	54.00
54.01	05401	353,719	137,072	490,791	4,599	495,390	54.01
57.00	05700	136,873	72,635	209,508	1,254	210,762	57.00
58.00	05800	179,038	168,158	347,196	2,116	349,312	58.00
59.00	05900	322,957	2,924,816	3,247,773	-1,868,610	1,379,163	59.00
60.00	06000	2,200,840	2,779,360	4,980,200	26,269	5,006,469	60.00
64.00	06400	0	309,510	309,510	0	309,510	64.00
65.00	06500	651,627	296,374	948,001	-167,551	780,450	65.00
66.00	06600	1,402,774	245,937	1,648,711	-65,333	1,583,378	66.00
67.00	06700	281,572	39,259	320,831	41,611	362,442	67.00
68.00	06800	276,600	144,704	421,304	-100,156	321,148	68.00
69.00	06900	232,935	31,383	264,318	183,724	448,042	69.00
70.00	07000	265,979	40,985	306,964	3,776	310,740	70.00
71.00	07100	0	0	0	1,475,527	1,475,527	71.00
72.00	07200	0	0	0	5,759,302	5,759,302	72.00
73.00	07300	0	0	0	1,992,990	1,992,990	73.00
76.00	03550	354,356	430,225	784,581	4,531	789,112	76.00
76.97	07697	408,785	144,061	552,846	-45,180	507,666	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	23,034,244	6,832,550	29,866,794	-2,219,993	27,646,801	90.00
91.00	09100	4,661,104	1,503,204	6,164,308	10,623	6,174,931	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	690,391	164,885	855,276	1,692	856,968	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		718,152	718,152	-718,152	0	113.00
118.00		59,182,557	75,573,394	134,755,951	-718	134,755,233	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	6,255	6,255	0	6,255	190.00
192.00	19200	242,637	52,656	295,293	718	296,011	192.00
194.00	07950	0	0	0	0	0	194.00
200.00		59,425,194	75,632,305	135,057,499	0	135,057,499	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0012

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

Worksheet A
Date/Time Prepared:
5/30/2019 2:58 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-287,957	4,553,612	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,639,299	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,533	17,091,460	4.00
5.01	00540	NONPATIENT TELEPHONES	-15,606	715,169	5.01
5.02	00590	DATA PROCESSING	0	4,416,140	5.02
5.03	00591	PURCHASING RECEIVING AND STORES	-8,279	1,177,200	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	5,086,808	5.04
5.05	00592	OTHER ADMIN & GENERAL	-4,320,994	8,792,914	5.05
7.00	00700	OPERATION OF PLANT	-463,172	2,971,631	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	297,023	8.00
9.00	00900	HOUSEKEEPING	0	1,186,091	9.00
10.00	01000	DIETARY	0	355,750	10.00
11.00	01100	CAFETERIA	-403,890	1,009,079	11.00
13.00	01300	NURSING ADMINISTRATION	-24,714	1,678,045	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	60,536	14.00
15.00	01500	PHARMACY	-1,217,519	1,336,591	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-49,805	2,356,366	16.00
17.00	01700	SOCIAL SERVICE	-838	78,911	17.00
17.01	01701	UTILIZATION REVIEW	0	229,747	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	933,192	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	481,497	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	4,288,395	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,383,483	31.00
40.00	04000	SUBPROVIDER - I PF	-514,800	1,153,783	40.00
43.00	04300	NURSERY	0	522,946	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	3,298,954	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	190,524	52.00
53.00	05300	ANESTHESIOLOGY	-1,020,521	79,070	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-7,100	2,293,186	54.00
54.01	05401	ULTRASOUND	0	495,390	54.01
57.00	05700	CT SCAN	0	210,762	57.00
58.00	05800	MRI	0	349,312	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,379,163	59.00
60.00	06000	LABORATORY	-320,154	4,686,315	60.00
64.00	06400	INTRAVENOUS THERAPY	0	309,510	64.00
65.00	06500	RESPIRATORY THERAPY	0	780,450	65.00
66.00	06600	PHYSICAL THERAPY	0	1,583,378	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	362,442	67.00
68.00	06800	SPEECH PATHOLOGY	0	321,148	68.00
69.00	06900	ELECTROCARDIOLOGY	0	448,042	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	310,740	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	1,475,527	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,759,302	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,992,990	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	-659,935	129,177	76.00
76.97	07697	CARDIAC REHABILITATION	0	507,666	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-18,540,382	9,106,419	90.00
91.00	09100	EMERGENCY	-2,818,234	3,356,697	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	856,968	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-30,676,433	104,078,800	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	6,255	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	296,011	192.00
194.00	07950	MEALS ON WHEELS	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-30,676,433	104,381,066	200.00

RECLASSIFICATIONS

Provider CCN: 14-0012

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

Worksheet A-6
Date/Time Prepared:
5/30/2019 2:58 pm

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - DIETARY TO CAFETERIA						
1.00	CAFETERIA	11.00	852,203	560,766	1.00	
	O		852,203	560,766		
B - LABOR & DELIVERY						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	127,614	60,003	1.00	
	O		127,614	60,003		
C - INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	718,152	1.00	
	O		0	718,152		
D - COMMUNICATIONS EXPENSE						
1.00	NONPATIENT TELEPHONES	5.01	0	294,809	1.00	
	O		0	294,809		
E - BILLABLE SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	1,461,886	1.00	
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	5,759,302	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	
	O		0	7,221,188		
F - BILLABLE DRUGS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,992,990	1.00	
	O		0	1,992,990		
G - PROPERTY INSURANCE						
1.00	OTHER CAP REL COSTS	3.00	0	202,264	1.00	
	O		0	202,264		
H - PT DIRECTOR SALARY						
1.00	OCCUPATIONAL THERAPY	67.00	46,300	0	1.00	
2.00	SPEECH PATHOLOGY	68.00	14,948	0	2.00	
	O		61,248	0		
I - BIO-MED COSTS						
1.00	OTHER ADMIN & GENERAL	5.05	0	309	1.00	
2.00	PHARMACY	15.00	0	13,967	2.00	
3.00	ADULTS & PEDIATRICS	30.00	0	2,418	3.00	
4.00	INTENSIVE CARE UNIT	31.00	0	3,094	4.00	
5.00	SUBPROVIDER - IPF	40.00	0	203	5.00	
6.00	NURSERY	43.00	0	2,011	6.00	
7.00	OPERATING ROOM	50.00	0	50,923	7.00	
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	2,907	8.00	
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	359	9.00	
10.00	LABORATORY	60.00	0	2,965	10.00	
11.00	RESPIRATORY THERAPY	65.00	0	10,958	11.00	
12.00	PHYSICAL THERAPY	66.00	0	1,306	12.00	
13.00	CARDIAC CATHETERIZATION	59.00	0	2,706	13.00	
14.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	13,641	14.00	
15.00	CARDIAC REHABILITATION	76.97	0	1,093	15.00	
16.00	CLINIC	90.00	0	25,083	16.00	
17.00	EMERGENCY	91.00	0	4,312	17.00	
	O		0	138,255		
J - HOUSEKEEPING						
1.00	DATA PROCESSING	5.02	770	59	1.00	
2.00	PURCHASING RECEIVING AND STORES	5.03	12,015	919	2.00	
3.00	CASHIERING/ACCOUNTS RECEIVABLE	5.04	4,065	311	3.00	
4.00	OTHER ADMIN & GENERAL	5.05	6,626	507	4.00	
5.00	OPERATION OF PLANT	7.00	12,101	926	5.00	

RECLASSIFICATIONS

Provider CCN: 14-0012

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

Worksheet A-6
Date/Time Prepared:
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		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
6.00	RADIOLOGY-DIAGNOSTIC	54.00	2,823	216	6.00
7.00	ULTRASOUND	54.01	1,314	101	7.00
8.00	LABORATORY	60.00	1,246	95	8.00
9.00	PHYSICAL THERAPY	66.00	5,760	441	9.00
10.00	OCCUPATIONAL THERAPY	67.00	5,760	441	10.00
11.00	SPEECH PATHOLOGY	68.00	735	56	11.00
12.00	CARDIAC REHABILITATION	76.97	4,501	344	12.00
13.00	ELECTROENCEPHALOGRAPHY	70.00	2,107	161	13.00
14.00	CLINIC	90.00	84,037	6,428	14.00
	O		143,860	11,005	
K - UTILIZATION REVIEW					
1.00	UTILIZATION REVIEW	17.01	210,281	16,086	1.00
2.00		0.00	0	0	2.00
	O		210,281	16,086	
L - MEDICAL DIRECTOR					
1.00	UTILIZATION REVIEW	17.01	3,380	0	1.00
	O		3,380	0	
M - MEDICAL DIRECTOR TIME					
1.00	MEDICAL RECORDS & LIBRARY	16.00	73,221	0	1.00
2.00		0.00	0	0	2.00
	O		73,221	0	
O - RESIDENCY COSTS					
1.00	I&R SERVICES-SALARY & FRINGES A	21.00	301,391	631,801	1.00
2.00	I&R SERVICES-OTHER PRGM COSTS A	22.00	396,999	84,498	2.00
	O		698,390	716,299	
P - CODER SALARIES					
1.00	CLINIC	90.00	87,190	6,670	1.00
	O		87,190	6,670	
R - EKG SALARIES					
1.00	ELECTROCARDIOLOGY	69.00	119,236	62,526	1.00
	O		119,236	62,526	
S - PATIENT ADVOCATE SALARIES					
1.00	SOCIAL SERVICE	17.00	74,082	5,667	1.00
	O		74,082	5,667	
T - MOVABLE EQUIPMENT					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,579,171	1.00
	O		0	1,579,171	
U - WORKERS COMPENSATION					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	89,741	1.00
	O		0	89,741	
V - BONUS PAY					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	13,251	0	1.00
2.00	NONPATIENT TELEPHONES	5.01	6,068	0	2.00
3.00	DATA PROCESSING	5.02	8,571	0	3.00
4.00	PURCHASING RECEIVING AND STORES	5.03	6,998	0	4.00
5.00	CASHIERING/ACCOUNTS RECEIVABLE	5.04	43,171	0	5.00
6.00	OTHER ADMIN & GENERAL	5.05	136,510	0	6.00
7.00	OPERATION OF PLANT	7.00	10,049	0	7.00
8.00	HOUSEKEEPING	9.00	17,439	0	8.00
9.00	DIETARY	10.00	21,236	0	9.00
10.00	NURSING ADMINISTRATION	13.00	16,448	0	10.00
11.00	PHARMACY	15.00	7,143	0	11.00
12.00	MEDICAL RECORDS & LIBRARY	16.00	13,059	0	12.00
13.00	ADULTS & PEDIATRICS	30.00	37,118	0	13.00
14.00	INTENSIVE CARE UNIT	31.00	10,011	0	14.00
15.00	SUBPROVIDER - IPF	40.00	11,886	0	15.00
16.00	NURSERY	43.00	3,253	0	16.00
17.00	OPERATING ROOM	50.00	24,143	0	17.00
18.00	RADIOLOGY-DIAGNOSTIC	54.00	15,360	0	18.00
19.00	ULTRASOUND	54.01	3,184	0	19.00
20.00	CT SCAN	57.00	1,254	0	20.00
21.00	MRI	58.00	2,116	0	21.00
22.00	CARDIAC CATHETERIZATION	59.00	3,754	0	22.00
23.00	LABORATORY	60.00	22,342	0	23.00
24.00	RESPIRATORY THERAPY	65.00	5,459	0	24.00
25.00	PHYSICAL THERAPY	66.00	14,537	0	25.00
26.00	OCCUPATIONAL THERAPY	67.00	2,627	0	26.00
27.00	SPEECH PATHOLOGY	68.00	2,077	0	27.00
28.00	ELECTROCARDIOLOGY	69.00	2,018	0	28.00
29.00	ELECTROENCEPHALOGRAPHY	70.00	3,113	0	29.00

RECLASSIFICATIONS

Provider CCN: 14-0012

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

Worksheet A-6

Date/Time Prepared:
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		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
30.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	4,531	0		30.00
31.00	CARDIAC REHABILITATION	76.97	4,096	0		31.00
32.00	CLINIC	90.00	100,895	0		32.00
33.00	EMERGENCY	91.00	24,795	0		33.00
34.00	HOME HEALTH AGENCY	101.00	6,436	0		34.00
35.00	PHYSICIANS' PRIVATE OFFICES	192.00	718	0		35.00
	TOTALS		605,666	0		
500.00	Grand Total: Increases		3,056,371	13,675,592		500.00

RECLASSIFICATIONS

Provider CCN: 14-0012

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

Worksheet A-6
Date/Time Prepared:
5/30/2019 2:58 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - DIETARY TO CAFETERIA							
1.00	DIETARY	10.00	852,203	560,766	0		1.00
	O		852,203	560,766			
B - LABOR & DELIVERY							
1.00	ADULTS & PEDIATRICS	30.00	127,614	60,003	0		1.00
	O		127,614	60,003			
C - INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	718,152	11		1.00
	O		0	718,152			
D - COMMUNICATIONS EXPENSE							
1.00	DATA PROCESSING	5.02	0	294,809	0		1.00
	O		0	294,809			
E - BILLABLE SUPPLIES							
1.00	OPERATION OF PLANT	7.00	0	45,023	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	3,734,392	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	1,874	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	1,068	0		4.00
5.00	NURSERY	43.00	0	12	0		5.00
6.00	OPERATING ROOM	50.00	0	263,080	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	21,182	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	175	0		8.00
9.00	CARDIAC CATHETERIZATION	59.00	0	1,875,070	0		9.00
10.00	LABORATORY	60.00	0	379	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	2,206	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	26,129	0		12.00
13.00	OCCUPATIONAL THERAPY	67.00	0	13,517	0		13.00
14.00	SPEECH PATHOLOGY	68.00	0	117,972	0		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	56	0		15.00
16.00	ELECTROENCEPHALOGRAPHY	70.00	0	1,605	0		16.00
17.00	CARDIAC REHABILITATION	76.97	0	55,214	0		17.00
18.00	CLINIC	90.00	0	1,046,135	0		18.00
19.00	EMERGENCY	91.00	0	11,355	0		19.00
20.00	HOME HEALTH AGENCY	101.00	0	4,744	0		20.00
	O		0	7,221,188			
F - BILLABLE DRUGS							
1.00	PHARMACY	15.00	0	1,992,990	0		1.00
	O		0	1,992,990			
G - PROPERTY INSURANCE							
1.00	OTHER ADMIN & GENERAL	5.05	0	202,264	12		1.00
	O		0	202,264			
H - PT DIRECTOR SALARY							
1.00	PHYSICAL THERAPY	66.00	61,248	0	0		1.00
2.00		0.00	0	0	0		2.00
	O		61,248	0			
I - BIO-MED COSTS							
1.00	OPERATION OF PLANT	7.00	0	138,255	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
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
	O		0	138,255			
J - HOUSEKEEPING							
1.00	HOUSEKEEPING	9.00	143,860	11,005	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
10.00		0.00	0	0	0		10.00

RECLASSIFICATIONS

Provider CCN: 14-0012

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

Worksheet A-6
Date/Time Prepared:
5/30/2019 2:58 pm

Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
			143,860	11,005			
K - UTILIZATION REVIEW							
1.00	MEDICAL RECORDS & LIBRARY	16.00	50,918	3,895	0		1.00
2.00	NURSING ADMINISTRATION	13.00	159,363	12,191	0		2.00
			210,281	16,086			
L - MEDICAL DIRECTOR							
1.00	CLINIC	90.00	3,380	0	0		1.00
			3,380	0			
M - MEDICAL DIRECTOR TIME							
1.00	CLINIC	90.00	66,092	0	0		1.00
2.00	EMERGENCY	91.00	7,129	0	0		2.00
			73,221	0			
O - RESIDENCY COSTS							
1.00	CLINIC	90.00	698,390	716,299	0		1.00
2.00		0.00	0	0	0		2.00
			698,390	716,299			
P - CODER SALARIES							
1.00	MEDICAL RECORDS & LIBRARY	16.00	87,190	6,670	0		1.00
			87,190	6,670			
R - EKG SALARIES							
1.00	RESPIRATORY THERAPY	65.00	119,236	62,526	0		1.00
			119,236	62,526			
S - PATIENT ADVOCATE SALARIES							
1.00	NURSING ADMINISTRATION	13.00	74,082	5,667	0		1.00
			74,082	5,667			
T - MOVABLE EQUIPMENT							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,579,171	9		1.00
			0	1,579,171			
U - WORKERS COMPENSATION							
1.00	OTHER ADMIN & GENERAL	5.05	0	89,741	0		1.00
			0	89,741			
V - BONUS PAY							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	605,666	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
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
27.00		0.00	0	0	0		27.00
28.00		0.00	0	0	0		28.00
29.00		0.00	0	0	0		29.00
30.00		0.00	0	0	0		30.00
31.00		0.00	0	0	0		31.00
32.00		0.00	0	0	0		32.00
33.00		0.00	0	0	0		33.00
34.00		0.00	0	0	0		34.00
35.00		0.00	0	0	0		35.00
	TOTALS		605,666	0			
500.00	Grand Total: Decreases		3,056,371	13,675,592			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0012

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

Worksheet A-7
Part I
Date/Time Prepared:
5/30/2019 2:58 pm

		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	2,183,972	159,067	0	159,067	0	1.00
2.00	Land Improvements	5,458,463	52,942	0	52,942	1,060	2.00
3.00	Buildings and Fixtures	49,401,702	1,067,328	0	1,067,328	208,798	3.00
4.00	Building Improvements	49,578	720,492	0	720,492	0	4.00
5.00	Fixed Equipment	32,287,220	587,518	0	587,518	15,733	5.00
6.00	Movable Equipment	37,684,813	2,440,689	0	2,440,689	1,314,987	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	127,065,748	5,028,036	0	5,028,036	1,540,578	8.00
9.00	Reconciling Items	499,719	9,418,864	0	9,418,864	3,808,771	9.00
10.00	Total (line 8 minus line 9)	126,566,029	-4,390,828	0	-4,390,828	-2,268,193	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,343,039	0				1.00
2.00	Land Improvements	5,510,345	0				2.00
3.00	Buildings and Fixtures	50,260,232	0				3.00
4.00	Building Improvements	770,070	0				4.00
5.00	Fixed Equipment	32,859,005	0				5.00
6.00	Movable Equipment	38,810,515	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	130,553,206	0				8.00
9.00	Reconciling Items	6,109,812	0				9.00
10.00	Total (line 8 minus line 9)	124,443,394	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0012

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

Worksheet A-7
Part II
Date/Time Prepared:
5/30/2019 2:58 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	5,560,452	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,560,452	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	5,560,452				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	5,560,452				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0012

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

Worksheet A-7
Part III
Date/Time Prepared:
5/30/2019 2:58 pm

Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	91,742,691	0	91,742,691	0.702723	142,136	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	38,810,515	0	38,810,515	0.297277	60,128	2.00
3.00	Total (sum of lines 1-2)	130,553,206	0	130,553,206	1.000000	202,264	3.00
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
	6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	142,136	3,981,281	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	60,128	1,579,171	0	2.00
3.00	Total (sum of lines 1-2)	0	0	202,264	5,560,452	0	3.00
Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	430,195	142,136	0	0	4,553,612	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	60,128	0	0	1,639,299	2.00
3.00	Total (sum of lines 1-2)	430,195	202,264	0	0	6,192,911	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0012

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

Worksheet A-8

Date/Time Prepared:
5/30/2019 2:58 pm

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.	
				Cost Center		Line #		
				1.00	2.00	3.00		4.00
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-287,957	CAP REL COSTS-BLDG & FIXT		1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP		2.00		0 2.00
3.00	Investment income - other (chapter 2)		0			0.00		0 3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-8,279	PURCHASING RECEIVING AND STORES		5.03		0 4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-29,106	OTHER ADMIN & GENERAL		5.05		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	-15,606	NONPATIENT TELEPHONES		5.01		0 7.00
8.00	Television and radio service (chapter 21)	A	-27,606	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	-23,874,559					0 10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0			0.00		0 11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0					0 12.00
13.00	Laundry and linen service		0			0.00		0 13.00
14.00	Cafeteria-employees and guests	B	-403,890	CAFETERIA		11.00		0 14.00
15.00	Rental of quarters to employee and others		0			0.00		0 15.00
16.00	Sale of medical and surgical supplies to other than patients		0			0.00		0 16.00
17.00	Sale of drugs to other than patients		0			0.00		0 17.00
18.00	Sale of medical records and abstracts	B	-42,730	MEDICAL RECORDS & LIBRARY		16.00		0 18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0			0.00		0 19.00
20.00	Vending machines		0			0.00		0 20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00		0 21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00		0 22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY		65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY		66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***		114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT		1.00		0 26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP		2.00		0 27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***		19.00		28.00
29.00	Physicians' assistant		0			0.00		0 29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY		67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS		30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY		68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0			0.00		0 32.00
33.00	MISCELLANEOUS INCOME	B	-66,733	OTHER ADMIN & GENERAL		5.05		0 33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0012

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

Worksheet A-8

Date/Time Prepared:
5/30/2019 2:58 pm

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 MISCELLANEOUS INCOME	B	-399	OPERATION OF PLANT	7.00	0 33.01
33.02 MISCELLANEOUS INCOME	B	-7,369	CLINIC	90.00	0 33.02
34.00 RETAIL PHARMACY 340B	A	-1,217,519	PHARMACY	15.00	0 34.00
35.00 NONALLOWABLE COSTS	A	-274,497	OTHER ADMIN & GENERAL	5.05	0 35.00
35.01 NONALLOWABLE COSTS	A	-11	CLINIC	90.00	0 35.01
36.00 EDUCATION REV (LIFE SUPPORT, CARE CO	B	-24,714	NURSING ADMINISTRATION	13.00	0 36.00
37.00 SPECIAL PROGRAM & SALE OF RADIOLOGY	B	-7,100	RADIOLOGY-DIAGNOSTIC	54.00	0 37.00
38.00 NON ALLOW ADVERTISING	A	-74,970	OTHER ADMIN & GENERAL	5.05	0 38.00
40.00 INCOME TAX EXPENSE	A	-44,746	OTHER ADMIN & GENERAL	5.05	0 40.00
40.01 RENTAL REVENUE	B	-435,167	OPERATION OF PLANT	7.00	0 40.01
40.02 AHA & IHA LOBBYING DUES	A	-32,160	OTHER ADMIN & GENERAL	5.05	0 40.02
41.00 EMPLOYEE PHYSICALS	A	-2,533	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 41.00
42.00 PHYSICIAN RECRUITMENT COSTS	A	-121,756	OTHER ADMIN & GENERAL	5.05	0 42.00
43.00 IPA TAX	A	-3,677,026	OTHER ADMIN & GENERAL	5.05	0 43.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-30,676,433			50.00

- (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
 - (2) Basis for adjustment (see instructions).
 - A. Costs - if cost, including applicable overhead, can be determined.
 - B. Amount Received - if cost cannot be determined.
 - (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
- Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0012

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

Worksheet A-8-2

Date/Time Prepared:
5/30/2019 2:58 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	16.00	MEDICAL RECORDS & LIBRARY	73,221	0	73,211	211,500	638	1.00
2.00	17.00	SOCIAL SERVICE	3,380	0	3,380	211,500	25	2.00
3.00	40.00	SUBPROVIDER - IPF	514,800	514,800	0	181,300	0	3.00
4.00	53.00	ANESTHESIOLOGY	1,020,521	1,020,521	0	239,400	0	4.00
5.00	60.00	LABORATORY	358,869	307,231	51,638	260,300	295	5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	211,500	0	6.00
7.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	659,935	659,935	0	181,300	0	7.00
8.00	90.00	CLINIC	18,778,764	18,500,827	277,937	211,500	2,377	8.00
9.00	91.00	EMERGENCY	3,511,262	1,332,586	2,178,676	211,500	6,627	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			24,920,752	22,335,900	2,584,842		9,962	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	16.00	MEDICAL RECORDS & LIBRARY	64,874	3,244	1,272	1,272	0	1.00
2.00	17.00	SOCIAL SERVICE	2,542	127	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	2,258	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	36,918	1,846	24,596	3,539	-343	5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	465	0	0	6.00
7.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	779	0	0	7.00
8.00	90.00	CLINIC	241,700	12,085	159,129	2,355	115,308	8.00
9.00	91.00	EMERGENCY	673,851	33,693	30,907	19,177	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,019,885	50,995	219,406	26,343	114,965	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	16.00	MEDICAL RECORDS & LIBRARY	0	66,146	7,065	7,075		1.00
2.00	17.00	SOCIAL SERVICE	0	2,542	838	838		2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	514,800		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	1,020,521		4.00
5.00	60.00	LABORATORY	-49	38,715	12,923	320,154		5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	0		6.00
7.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	659,935		7.00
8.00	90.00	CLINIC	1,707	245,762	32,175	18,533,002		8.00
9.00	91.00	EMERGENCY	0	693,028	1,485,648	2,818,234		9.00
10.00	0.00		0	0	0	0		10.00
200.00			1,658	1,046,193	1,538,649	23,874,559		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0012

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

Worksheet B
Part I
Date/Time Prepared:
5/30/2019 2:58 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	4,553,612	4,553,612			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	1,639,299		1,639,299		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	17,091,460	45,671	1,757	17,138,888	4.00
5.01 00540	NONPATIENT TELEPHONES	715,169	22,075	0	93,348	830,592 5.01
5.02 00590	DATA PROCESSING	4,416,140	91,879	381,411	248,642	31,651 5.02
5.03 00591	PURCHASING RECEIVING AND STORES	1,177,200	123,043	10,191	105,900	8,632 5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE	5,086,808	60,250	3,293	680,916	42,201 5.04
5.05 00592	OTHER ADMIN & GENERAL	8,792,914	101,433	50,455	1,172,106	50,833 5.05
7.00 00700	OPERATION OF PLANT	2,971,631	1,500,405	39,689	251,641	39,324 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	297,023	1,830	0	0	0 8.00
9.00 00900	HOUSEKEEPING	1,186,091	40,325	797	166,625	2,877 9.00
10.00 01000	DIETARY	355,750	55,990	2,764	59,214	16,305 10.00
11.00 01100	CAFETERIA	1,009,079	28,755	11,677	250,116	0 11.00
13.00 01300	NURSING ADMINISTRATION	1,678,045	26,573	84,263	333,402	15,346 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	60,536	22,448	473	0	1,918 14.00
15.00 01500	PHARMACY	1,336,591	26,532	42,293	240,262	11,509 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,356,366	24,464	16,423	216,160	18,223 16.00
17.00 01700	SOCIAL SERVICE	78,911	0	0	21,743	0 17.00
17.01 01701	UTILIZATION REVIEW	229,747	1,437	0	62,708	2,877 17.01
21.00 02100	I&R SERVICES-SALARY & FRINGES A	933,192	0	0	88,456	0 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS A	481,497	0	0	116,516	0 22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	4,288,395	446,812	75,581	990,468	20,141 30.00
31.00 03100	INTENSIVE CARE UNIT	1,383,483	45,888	37,748	285,694	9,591 31.00
40.00 04000	SUBPROVIDER - I/PF	1,153,783	64,510	4,115	307,977	11,509 40.00
43.00 04300	NURSERY	522,946	4,301	5,749	129,956	1,918 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	3,298,954	280,807	217,570	599,530	45,078 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	190,524	12,883	6,143	37,454	959 52.00
53.00 05300	ANESTHESIOLOGY	79,070	879	14,470	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,293,186	73,319	120,664	374,288	24,937 54.00
54.01 05401	ULTRASOUND	495,390	2,936	16,972	104,200	1,918 54.01
57.00 05700	CT SCAN	210,762	5,863	29,320	40,171	1,918 57.00
58.00 05800	MRI	349,312	5,129	7,397	52,546	1,918 58.00
59.00 05900	CARDIAC CATHETERIZATION	1,379,163	52,009	116,785	94,786	4,796 59.00
60.00 06000	LABORATORY	4,686,315	57,551	102,150	646,297	29,733 60.00
64.00 06400	INTRAVENOUS THERAPY	309,510	0	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	780,450	13,028	47,552	156,253	5,755 65.00
66.00 06600	PHYSICAL THERAPY	1,583,378	92,127	16,970	395,419	17,264 66.00
67.00 06700	OCCUPATIONAL THERAPY	362,442	0	0	97,919	2,877 67.00
68.00 06800	SPEECH PATHOLOGY	321,148	18,095	5,983	85,783	3,836 68.00
69.00 06900	ELECTROCARDIOLOGY	448,042	2,626	0	103,360	959 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	310,740	12,025	6,605	78,681	1,918 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	1,475,527	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	5,759,302	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,992,990	0	0	0	0 73.00
76.00 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	129,177	29,489	374	104,001	8,632 76.00
76.97 07697	CARDIAC REHABILITATION	507,666	0	0	121,297	959 76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	9,106,419	964,669	130,898	6,585,307	339,530 90.00
91.00 09100	EMERGENCY	3,356,697	145,057	29,913	1,365,909	37,405 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)					
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	856,968	37,895	854	202,625	12,468 101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	104,078,800	4,541,008	1,639,299	17,067,676	827,715 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	6,255	12,604	0	0	2,877 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	296,011	0	0	71,212	0 192.00
194.00 07950	MEALS ON WHEELS	0	0	0	0	0 194.00
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118 through 201)	104,381,066	4,553,612	1,639,299	17,138,888	830,592 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0012

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

Worksheet B
Part I
Date/Time Prepared:
5/30/2019 2:58 pm

Cost Center Description			DATA PROCESSING	PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMIN & GENERAL	
			5.02	5.03	5.04	5A.04	5.05	
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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00590	DATA PROCESSING	5,169,723					5.02
5.03	00591	PURCHASING RECEIVING AND STORES	79,447	1,504,413				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	238,341	2,144	6,113,953			5.04
5.05	00592	OTHER ADMIN & GENERAL	317,788	15,759	0	10,501,288	10,501,288	5.05
7.00	00700	OPERATION OF PLANT	62,423	73,081	0	4,938,194	552,381	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	298,853	33,429	8.00
9.00	00900	HOUSEKEEPING	0	12,555	0	1,409,270	157,640	9.00
10.00	01000	DIETARY	39,723	1,011	0	530,757	59,370	10.00
11.00	01100	CAFETERIA	0	4,272	0	1,303,899	145,853	11.00
13.00	01300	NURSING ADMINISTRATION	244,015	4,956	0	2,386,600	266,963	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,350	432,118	0	528,843	59,156	14.00
15.00	01500	PHARMACY	85,122	2,429	0	1,744,738	195,165	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	130,520	29,236	0	2,791,392	312,242	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	100,654	11,259	17.00
17.01	01701	UTILIZATION REVIEW	22,699	0	0	319,468	35,735	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	1,021,648	114,281	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	79,447	0	0	677,460	75,780	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	187,268	26,034	192,101	6,226,800	696,524	30.00
31.00	03100	INTENSIVE CARE UNIT	45,398	8,491	109,356	1,925,649	215,401	31.00
40.00	04000	SUBPROVIDER - I/PF	39,723	1,056	72,101	1,654,774	185,101	40.00
43.00	04300	NURSERY	0	7,714	14,528	687,112	76,860	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	204,292	126,085	636,714	5,409,030	605,049	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,886	20,182	270,031	30,205	52.00
53.00	05300	ANESTHESIOLOGY	0	9,203	88,950	192,572	21,541	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	96,471	56,225	220,214	3,259,304	364,582	54.00
54.01	05401	ULTRASOUND	0	4,796	114,317	740,529	82,835	54.01
57.00	05700	CT SCAN	5,675	8,524	432,295	734,528	82,164	57.00
58.00	05800	MRI	17,024	16,933	137,707	587,966	65,769	58.00
59.00	05900	CARDIAC CATHETERIZATION	79,447	79,435	322,017	2,128,438	238,085	59.00
60.00	06000	LABORATORY	175,918	179,433	630,891	6,508,288	728,011	60.00
64.00	06400	INTRAVENOUS THERAPY	0	17,948	88,352	415,810	46,512	64.00
65.00	06500	RESPIRATORY THERAPY	51,073	23,672	128,846	1,206,629	134,972	65.00
66.00	06600	PHYSICAL THERAPY	164,569	4,462	162,137	2,436,326	272,525	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,736	24,512	489,486	54,753	67.00
68.00	06800	SPEECH PATHOLOGY	45,398	14,381	18,156	512,780	57,359	68.00
69.00	06900	ELECTROCARDIOLOGY	45,398	2,303	140,387	743,075	83,120	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	28,374	1,810	46,073	486,226	54,389	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	431,847	1,907,374	213,357	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	112,581	5,871,883	656,823	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	670,205	2,663,195	297,902	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	62,423	20	14,879	348,995	39,038	76.00
76.97	07697	CARDIAC REHABILITATION	0	176,806	10,102	816,830	91,370	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,355,032	130,904	913,215	20,525,974	2,296,005	90.00
91.00	09100	EMERGENCY	175,918	24,694	342,767	5,478,360	612,804	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)				0		92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	79,447	2,301	17,386	1,209,944	135,343	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,169,723	1,504,413	6,112,818	103,990,972	10,457,653	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	21,736	2,431	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,135	368,358	41,204	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,169,723	1,504,413	6,113,953	104,381,066	10,501,288	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 14-0012		Period: From 01/01/2018 To 12/31/2018		Worksheet B Part I Date/Time Prepared: 5/30/2019 2:58 pm	
Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00590	DATA PROCESSING						5.02
5.03	00591	PURCHASING RECEIVING AND STORES						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00592	OTHER ADMIN & GENERAL						5.05
7.00	00700	OPERATION OF PLANT	5,490,575					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,852	336,134				8.00
9.00	00900	HOUSEKEEPING	84,868	0	1,651,778			9.00
10.00	01000	DIETARY	117,836	0	9,750	717,713		10.00
11.00	01100	CAFETERIA	60,517	0	13,000	0	1,523,269	11.00
13.00	01300	NURSING ADMINISTRATION	55,926	0	8,125	0	30,696	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	47,243	5,663	19,500	0	3,837	14.00
15.00	01500	PHARMACY	55,839	0	21,125	0	42,206	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	51,486	0	35,749	0	80,576	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	UTILIZATION REVIEW	3,025	0	1,625	0	11,511	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	38,369	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	940,357	99,533	379,429	359,826	191,847	30.00
31.00	03100	INTENSIVE CARE UNIT	96,575	18,438	47,124	48,578	49,880	31.00
40.00	04000	SUBPROVIDER - I/PF	135,767	7,551	51,999	82,824	53,717	40.00
43.00	04300	NURSERY	9,053	4,608	9,750	0	11,511	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	590,984	74,947	324,993	17,991	141,967	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	27,114	2,664	21,937	0	3,837	52.00
53.00	05300	ANESTHESIOLOGY	1,850	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	154,307	8,554	62,561	0	76,739	54.00
54.01	05401	ULTRASOUND	6,180	4,511	3,250	0	15,348	54.01
57.00	05700	CT SCAN	12,338	16,747	6,500	0	7,674	57.00
58.00	05800	MRI	10,793	5,352	5,687	0	11,511	58.00
59.00	05900	CARDIAC CATHETERIZATION	109,458	4,633	12,187	0	34,533	59.00
60.00	06000	LABORATORY	121,122	0	55,249	0	115,108	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	27,419	0	59,311	0	23,022	65.00
66.00	06600	PHYSICAL THERAPY	193,890	12,103	68,249	0	61,391	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	21,937	0	15,348	67.00
68.00	06800	SPEECH PATHOLOGY	38,082	0	10,562	0	15,348	68.00
69.00	06900	ELECTROCARDIOLOGY	5,527	0	12,187	0	26,859	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	25,308	0	8,125	0	7,674	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	62,062	0	10,562	0	23,022	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,030,231	0	128,372	0	249,402	90.00
91.00	09100	EMERGENCY	305,285	70,830	214,496	0	138,130	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	79,754	0	16,250	0	42,206	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,464,048	336,134	1,639,591	509,219	1,523,269	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	26,527	0	12,187	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	208,494	0	194.00
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)	5,490,575	336,134	1,651,778	717,713	1,523,269	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0012

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

Worksheet B
Part I
Date/Time Prepared:
5/30/2019 2:58 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00590						5.02
5.03	00591						5.03
5.04	00580						5.04
5.05	00592						5.05
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	2,748,310					13.00
14.00	01400	0	664,242				14.00
15.00	01500	0	0	2,059,073			15.00
16.00	01600	0	0	0	3,271,445		16.00
17.00	01700	0	0	0	0	111,913	17.00
17.01	01701	0	0	0	0	0	17.01
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	435,338	0	3,410	329,930	68,110	30.00
31.00	03100	123,154	0	838	240,783	16,190	31.00
40.00	04000	130,828	0	105	158,753	21,633	40.00
43.00	04300	41,551	0	274	31,987	5,980	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	232,748	0	6,220	319,914	0	50.00
52.00	05200	11,635	0	32	26,616	0	52.00
53.00	05300	0	0	0	52,729	0	53.00
54.00	05400	0	0	2,495	37,015	0	54.00
54.01	05401	0	0	193	19,561	0	54.01
57.00	05700	0	0	263	165,540	0	57.00
58.00	05800	0	0	1,159	15,468	0	58.00
59.00	05900	42,005	0	1,727	182,046	0	59.00
60.00	06000	0	0	239	314,794	0	60.00
64.00	06400	0	0	157,295	100,342	0	64.00
65.00	06500	62,394	0	21,818	219,833	0	65.00
66.00	06600	0	0	1	27,261	0	66.00
67.00	06700	0	0	0	7,503	0	67.00
68.00	06800	0	0	0	3,012	0	68.00
69.00	06900	34,193	0	0	56,945	0	69.00
70.00	07000	33,192	0	0	345	0	70.00
71.00	07100	0	134,472	0	308,756	0	71.00
72.00	07200	0	529,770	0	16,991	0	72.00
73.00	07300	0	0	1,206,573	456,078	0	73.00
76.00	03550	41,659	0	52	27,076	0	76.00
76.97	07697	48,017	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	1,202,332	0	643,231	542	0	90.00
91.00	09100	227,197	0	13,094	151,625	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	82,067	0	54	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00							118.00
SUBTOTALS (SUM OF LINES 1 through 117)		2,748,310	664,242	2,059,073	3,271,445	111,913	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		2,748,310	664,242	2,059,073	3,271,445	111,913	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0012

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

Worksheet B
Part I
Date/Time Prepared:
5/30/2019 2:58 pm

Cost Center Description	UTILIZATION REVIEW	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		SERVICES-SALARY & FRINGES A	SERVICES-OTHER PRGM COSTS A			
	17.01	21.00	22.00	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
5.01 00540	NONPATIENT TELEPHONES					5.01
5.02 00590	DATA PROCESSING					5.02
5.03 00591	PURCHASING RECEIVING AND STORES					5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05 00592	OTHER ADMIN & GENERAL					5.05
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
17.01 01701	UTILIZATION REVIEW	371,364				17.01
21.00 02100	I&R SERVICES-SALARY & FRINGES A	0	1,135,929			21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS A	0		791,609		22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	226,010	856,979	597,213	11,411,306	-1,535,907
31.00 03100	INTENSIVE CARE UNIT	53,724	203,708	141,961	3,182,003	-345,669
40.00 04000	SUBPROVIDER - I PF	71,786	0	0	2,554,838	0
43.00 04300	NURSERY	19,844	75,242	52,435	1,026,207	-127,677
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	0	7,723,843	-209,597
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	394,071	0
53.00 05300	ANESTHESIOLOGY	0	0	0	268,692	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	3,965,557	0
54.01 05401	ULTRASOUND	0	0	0	872,407	0
57.00 05700	CT SCAN	0	0	0	1,025,754	0
58.00 05800	MRI	0	0	0	703,705	0
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	2,753,112	0
60.00 06000	LABORATORY	0	0	0	7,842,811	0
64.00 06400	INTRAVENOUS THERAPY	0	0	0	719,959	1,208,909
65.00 06500	RESPIRATORY THERAPY	0	0	0	1,755,398	0
66.00 06600	PHYSICAL THERAPY	0	0	0	3,071,746	0
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	589,027	0
68.00 06800	SPEECH PATHOLOGY	0	0	0	637,143	0
69.00 06900	ELECTROCARDIOLOGY	0	0	0	961,906	0
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	615,259	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	2,563,959	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,075,467	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,623,748	0
76.00 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	552,466	0
76.97 07697	CARDIAC REHABILITATION	0	0	0	956,217	0
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	27,076,089	-557
91.00 09100	EMERGENCY	0	0	0	7,211,821	-917,040
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)					0
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	0	0	1,565,618	0
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	371,364	1,135,929	791,609	103,700,129	-1,927,538
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	62,881	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	409,562	0
194.00 07950	MEALS ON WHEELS	0	0	0	208,494	0
200.00	Cross Foot Adjustments		0	0	0	0
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	371,364	1,135,929	791,609	104,381,066	-1,927,538

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0012

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

Worksheet B
Part I
Date/Time Prepared:
5/30/2019 2:58 pm

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
5.01	00540	NONPATIENT TELEPHONES	5.01
5.02	00590	DATA PROCESSING	5.02
5.03	00591	PURCAHSING RECEIVING AND STORES	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.04
5.05	00592	OTHER ADMIN & GENERAL	5.05
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
17.01	01701	UTILIZATION REVIEW	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES A	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	22.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	ULTRASOUND	54.01
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
64.00	06400	INTRAVENOUS THERAPY	64.00
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
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00
76.97	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	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 & CAN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	MEALS ON WHEELS	194.00
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: 14-0012

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

Worksheet B
Part II
Date/Time Prepared:
5/30/2019 2:58 pm

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	45,671	1,757	47,428	47,428 4.00
5.01 00540	NONPATIENT TELEPHONES	0	22,075	0	22,075	258 5.01
5.02 00590	DATA PROCESSING	0	91,879	381,411	473,290	688 5.02
5.03 00591	PURCHASING RECEIVING AND STORES	202,759	123,043	10,191	335,993	293 5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	60,250	3,293	63,543	1,884 5.04
5.05 00592	OTHER ADMIN & GENERAL	23,209	101,433	50,455	175,097	3,243 5.05
7.00 00700	OPERATION OF PLANT	7,405	1,500,405	39,689	1,547,499	696 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	1,830	0	1,830	0 8.00
9.00 00900	HOUSEKEEPING	0	40,325	797	41,122	461 9.00
10.00 01000	DIETARY	0	55,990	2,764	58,754	164 10.00
11.00 01100	CAFETERIA	0	28,755	11,677	40,432	692 11.00
13.00 01300	NURSING ADMINISTRATION	49,050	26,573	84,263	159,886	922 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	22,448	473	22,921	0 14.00
15.00 01500	PHARMACY	136,861	26,532	42,293	205,686	665 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	24,464	16,423	40,887	598 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	60 17.00
17.01 01701	UTILIZATION REVIEW	0	1,437	0	1,437	173 17.01
21.00 02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	245 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	322 22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	3,847	446,812	75,581	526,240	2,740 30.00
31.00 03100	INTENSIVE CARE UNIT	1,923	45,888	37,748	85,559	790 31.00
40.00 04000	SUBPROVIDER - IPF	0	64,510	4,115	68,625	852 40.00
43.00 04300	NURSERY	1,656	4,301	5,749	11,706	360 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	406,615	280,807	217,570	904,992	1,659 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	12,883	6,143	19,026	104 52.00
53.00 05300	ANESTHESIOLOGY	4,560	879	14,470	19,909	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	73,319	120,664	193,983	1,036 54.00
54.01 05401	ULTRASOUND	64,164	2,936	16,972	84,072	288 54.01
57.00 05700	CT SCAN	0	5,863	29,320	35,183	111 57.00
58.00 05800	MRI	0	5,129	7,397	12,526	145 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	52,009	116,785	168,794	262 59.00
60.00 06000	LABORATORY	76,524	57,551	102,150	236,225	1,788 60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	428	13,028	47,552	61,008	432 65.00
66.00 06600	PHYSICAL THERAPY	29,775	92,127	16,970	138,872	1,094 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	271 67.00
68.00 06800	SPEECH PATHOLOGY	0	18,095	5,983	24,078	237 68.00
69.00 06900	ELECTROCARDIOLOGY	0	2,626	0	2,626	286 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	12,025	6,605	18,630	218 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	29,489	374	29,863	288 76.00
76.97 07697	CARDIAC REHABILITATION	213,684	0	0	213,684	336 76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	287,139	964,669	130,898	1,382,706	18,230 90.00
91.00 09100	EMERGENCY	0	145,057	29,913	174,970	3,779 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	37,895	854	38,749	561 101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,509,599	4,541,008	1,639,299	7,689,906	47,231 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	0	12,604	0	12,604	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	197 192.00
194.00 07950	MEALS ON WHEELS	0	0	0	0	0 194.00
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118 through 201)	1,509,599	4,553,612	1,639,299	7,702,510	47,428 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0012

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

Worksheet B Part II Date/Time Prepared: 5/30/2019 2:58 pm

Cost Center Description		NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMIN & GENERAL	
		5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540	22,333					5.01
5.02	00590	851	474,829				5.02
5.03	00591	232	7,297	343,815			5.03
5.04	00580	1,135	21,891	490	88,943		5.04
5.05	00592	1,367	29,188	3,602	0	212,497	5.05
7.00	00700	1,057	5,733	16,702	0	11,180	7.00
8.00	00800	0	0	0	0	677	8.00
9.00	00900	77	0	2,869	0	3,191	9.00
10.00	01000	438	3,649	231	0	1,202	10.00
11.00	01100	0	0	976	0	2,952	11.00
13.00	01300	413	22,412	1,133	0	5,403	13.00
14.00	01400	52	1,042	98,751	0	1,197	14.00
15.00	01500	309	7,818	555	0	3,950	15.00
16.00	01600	490	11,988	6,682	0	6,320	16.00
17.00	01700	0	0	0	0	228	17.00
17.01	01701	77	2,085	0	0	723	17.01
21.00	02100	0	0	0	0	2,313	21.00
22.00	02200	0	7,297	0	0	1,534	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	542	17,200	5,950	2,795	14,097	30.00
31.00	03100	258	4,170	1,940	1,591	4,360	31.00
40.00	04000	309	3,649	241	1,049	3,746	40.00
43.00	04300	52	0	1,763	211	1,556	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,212	18,764	28,815	9,263	12,246	50.00
52.00	05200	26	0	431	294	611	52.00
53.00	05300	0	0	2,103	1,294	436	53.00
54.00	05400	671	8,861	12,850	3,204	7,379	54.00
54.01	05401	52	0	1,096	1,663	1,677	54.01
57.00	05700	52	521	1,948	6,289	1,663	57.00
58.00	05800	52	1,564	3,870	2,003	1,331	58.00
59.00	05900	129	7,297	18,154	4,685	4,819	59.00
60.00	06000	799	16,158	41,008	9,179	14,735	60.00
64.00	06400	0	0	4,102	1,285	941	64.00
65.00	06500	155	4,691	5,410	1,875	2,732	65.00
66.00	06600	464	15,115	1,020	2,359	5,516	66.00
67.00	06700	77	0	397	357	1,108	67.00
68.00	06800	103	4,170	3,287	264	1,161	68.00
69.00	06900	26	4,170	526	2,042	1,682	69.00
70.00	07000	52	2,606	414	670	1,101	70.00
71.00	07100	0	0	0	6,283	4,318	71.00
72.00	07200	0	0	0	1,638	13,294	72.00
73.00	07300	0	0	0	9,751	6,029	73.00
76.00	03550	232	5,733	5	216	790	76.00
76.97	07697	26	0	40,407	147	1,849	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	9,128	216,305	29,917	13,279	46,425	90.00
91.00	09100	1,006	16,158	5,644	4,987	12,403	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	335	7,297	526	253	2,739	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		22,256	474,829	343,815	88,926	211,614	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	77	0	0	0	49	190.00
192.00	19200	0	0	0	17	834	192.00
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		22,333	474,829	343,815	88,943	212,497	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0012	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part II Date/Time Prepared: 5/30/2019 2:58 pm				
Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA		
		7.00	8.00	9.00	10.00	11.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.01	00540	NONPATIENT TELEPHONES					5.01	
5.02	00590	DATA PROCESSING					5.02	
5.03	00591	PURCHASING RECEIVING AND STORES					5.03	
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04	
5.05	00592	OTHER ADMIN & GENERAL					5.05	
7.00	00700	OPERATION OF PLANT	1,582,867				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	1,110	3,617			8.00	
9.00	00900	HOUSEKEEPING	24,466	0	72,186		9.00	
10.00	01000	DIETARY	33,971	0	426	98,835	10.00	
11.00	01100	CAFETERIA	17,446	0	568	0	63,066	11.00
13.00	01300	NURSING ADMINISTRATION	16,123	0	355	0	1,271	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,620	61	852	0	159	14.00
15.00	01500	PHARMACY	16,098	0	923	0	1,747	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,843	0	1,562	0	3,336	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	UTILIZATION REVIEW	872	0	71	0	477	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	1,589	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	271,094	1,070	16,581	49,550	7,943	30.00
31.00	03100	INTENSIVE CARE UNIT	27,841	198	2,059	6,690	2,065	31.00
40.00	04000	SUBPROVIDER - I/PF	39,140	81	2,272	11,406	2,224	40.00
43.00	04300	NURSERY	2,610	50	426	0	477	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	170,374	807	14,203	2,478	5,878	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,817	29	959	0	159	52.00
53.00	05300	ANESTHESIOLOGY	533	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	44,485	92	2,734	0	3,177	54.00
54.01	05401	ULTRASOUND	1,782	49	142	0	635	54.01
57.00	05700	CT SCAN	3,557	180	284	0	318	57.00
58.00	05800	MRI	3,112	58	249	0	477	58.00
59.00	05900	CARDIAC CATHETERIZATION	31,555	50	533	0	1,430	59.00
60.00	06000	LABORATORY	34,918	0	2,414	0	4,766	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	7,905	0	2,592	0	953	65.00
66.00	06600	PHYSICAL THERAPY	55,896	130	2,983	0	2,542	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	959	0	635	67.00
68.00	06800	SPEECH PATHOLOGY	10,978	0	462	0	635	68.00
69.00	06900	ELECTROCARDIOLOGY	1,593	0	533	0	1,112	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,296	0	355	0	318	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	17,892	0	462	0	953	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	585,291	0	5,610	0	10,324	90.00
91.00	09100	EMERGENCY	88,010	762	9,374	0	5,719	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	22,992	0	710	0	1,747	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,575,220	3,617	71,653	70,124	63,066	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	7,647	0	533	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	28,711	0	194.00
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)	1,582,867	3,617	72,186	98,835	63,066	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0012

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

Worksheet B
Part II
Date/Time Prepared:
5/30/2019 2:58 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00590						5.02
5.03	00591						5.03
5.04	00580						5.04
5.05	00592						5.05
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	207,918					13.00
14.00	01400	0	138,655				14.00
15.00	01500	0	0	237,751			15.00
16.00	01600	0	0	0	86,706		16.00
17.00	01700	0	0	0	0	288	17.00
17.01	01701	0	0	0	0	0	17.01
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	32,935	0	394	8,741	175	30.00
31.00	03100	9,317	0	97	6,379	42	31.00
40.00	04000	9,898	0	12	4,206	56	40.00
43.00	04300	3,143	0	32	847	15	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	17,608	0	718	8,476	0	50.00
52.00	05200	880	0	4	705	0	52.00
53.00	05300	0	0	0	1,397	0	53.00
54.00	05400	0	0	288	981	0	54.00
54.01	05401	0	0	22	518	0	54.01
57.00	05700	0	0	30	4,386	0	57.00
58.00	05800	0	0	134	410	0	58.00
59.00	05900	3,178	0	199	4,823	0	59.00
60.00	06000	0	0	28	8,340	0	60.00
64.00	06400	0	0	18,162	2,659	0	64.00
65.00	06500	4,720	0	2,519	5,824	0	65.00
66.00	06600	0	0	0	722	0	66.00
67.00	06700	0	0	0	199	0	67.00
68.00	06800	0	0	0	80	0	68.00
69.00	06900	2,587	0	0	1,509	0	69.00
70.00	07000	2,511	0	0	9	0	70.00
71.00	07100	0	28,070	0	8,180	0	71.00
72.00	07200	0	110,585	0	450	0	72.00
73.00	07300	0	0	139,317	12,117	0	73.00
76.00	03550	3,152	0	6	717	0	76.00
76.97	07697	3,633	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	90,959	0	74,271	14	0	90.00
91.00	09100	17,188	0	1,512	4,017	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	6,209	0	6	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		207,918	138,655	237,751	86,706	288	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		207,918	138,655	237,751	86,706	288	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0012

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

Worksheet B
Part II
Date/Time Prepared:
5/30/2019 2:58 pm

Cost Center Description	UTILIZATION REVIEW	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		SERVICES-SALARY & FRINGES A	SERVICES-OTHER PRGM COSTS A			
	17.01	21.00	22.00	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
5.01 00540	NONPATIENT TELEPHONES					5.01
5.02 00590	DATA PROCESSING					5.02
5.03 00591	PURCHASING RECEIVING AND STORES					5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05 00592	OTHER ADMIN & GENERAL					5.05
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
17.01 01701	UTILIZATION REVIEW	5,915				17.01
21.00 02100	I&R SERVICES-SALARY & FRINGES A	0	2,558			21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS A	0		10,742		22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	3,600		961,647	0	30.00
31.00 03100	INTENSIVE CARE UNIT	856		154,212	0	31.00
40.00 04000	SUBPROVIDER - I PF	1,143		148,909	0	40.00
43.00 04300	NURSERY	316		23,564	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0		1,197,493	0	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0		31,045	0	52.00
53.00 05300	ANESTHESIOLOGY	0		25,672	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0		279,741	0	54.00
54.01 05401	ULTRASOUND	0		91,996	0	54.01
57.00 05700	CT SCAN	0		54,522	0	57.00
58.00 05800	MRI	0		25,931	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0		245,908	0	59.00
60.00 06000	LABORATORY	0		370,358	0	60.00
64.00 06400	INTRAVENOUS THERAPY	0		27,149	0	64.00
65.00 06500	RESPIRATORY THERAPY	0		100,816	0	65.00
66.00 06600	PHYSICAL THERAPY	0		226,713	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0		4,003	0	67.00
68.00 06800	SPEECH PATHOLOGY	0		45,455	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0		18,692	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0		34,180	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0		46,851	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0		125,967	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0		167,214	0	73.00
76.00 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0		60,309	0	76.00
76.97 07697	CARDIAC REHABILITATION	0		260,082	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0		2,482,459	0	90.00
91.00 09100	EMERGENCY	0		345,529	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)				0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0		82,124	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	5,915	0	7,638,541	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	0		20,910	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0		1,048	0	192.00
194.00 07950	MEALS ON WHEELS	0		28,711	0	194.00
200.00	Cross Foot Adjustments		2,558	10,742	13,300	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	5,915	2,558	10,742	7,702,510	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0012	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part II Date/Time Prepared: 5/30/2019 2:58 pm
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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
5.01	00540	NONPATIENT TELEPHONES	5.01
5.02	00590	DATA PROCESSING	5.02
5.03	00591	PURCAHSING RECEIVING AND STORES	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.04
5.05	00592	OTHER ADMIN & GENERAL	5.05
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
17.01	01701	UTILIZATION REVIEW	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES A	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	22.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	ULTRASOUND	54.01
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
64.00	06400	INTRAVENOUS THERAPY	64.00
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
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00
76.97	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	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 & CAN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	MEALS ON WHEELS	194.00
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: 14-0012

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

Worksheet B-1

Date/Time Prepared:
5/30/2019 2:58 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (TELEPHONES)	DATA PROCESSING (NUMBER OF MACHINES)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	440,398				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		1,579,171			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	4,417	1,693	58,396,147		4.00
5.01 00540	NONPATIENT TELEPHONES	2,135	0	318,058	866	5.01
5.02 00590	DATA PROCESSING	8,886	367,419	847,182	33	911 5.02
5.03 00591	PURCHASING RECEIVING AND STORES	11,900	9,817	360,826	9	14 5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE	5,827	3,172	2,320,042	44	42 5.04
5.05 00592	OTHER ADMIN & GENERAL	9,810	48,604	3,993,642	53	56 5.05
7.00 00700	OPERATION OF PLANT	145,110	38,233	857,400	41	11 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	177	0	0	0	0 8.00
9.00 00900	HOUSEKEEPING	3,900	768	567,730	3	0 9.00
10.00 01000	DIETARY	5,415	2,663	201,755	17	7 10.00
11.00 01100	CAFETERIA	2,781	11,249	852,203	0	0 11.00
13.00 01300	NURSING ADMINISTRATION	2,570	81,172	1,135,980	16	43 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	2,171	456	0	2	2 14.00
15.00 01500	PHARMACY	2,566	40,742	818,628	12	15 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,366	15,821	736,508	19	23 16.00
17.00 01700	SOCIAL SERVICE	0	0	74,082	0	0 17.00
17.01 01701	UTILIZATION REVIEW	139	0	213,661	3	4 17.01
21.00 02100	I&R SERVICES-SALARY & FRINGES A	0	0	301,391	0	0 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	396,999	0	14 22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	43,213	72,809	3,374,760	21	33 30.00
31.00 03100	INTENSIVE CARE UNIT	4,438	36,363	973,427	10	8 31.00
40.00 04000	SUBPROVIDER - I/PF	6,239	3,964	1,049,352	12	7 40.00
43.00 04300	NURSERY	416	5,538	442,790	2	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	27,158	209,590	2,042,739	47	36 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,246	5,918	127,614	1	0 52.00
53.00 05300	ANESTHESIOLOGY	85	13,939	0	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	7,091	116,238	1,275,288	26	17 54.00
54.01 05401	ULTRASOUND	284	16,349	355,033	2	0 54.01
57.00 05700	CT SCAN	567	28,245	136,873	2	1 57.00
58.00 05800	MRI	496	7,126	179,038	2	3 58.00
59.00 05900	CARDIAC CATHETERIZATION	5,030	112,501	322,957	5	14 59.00
60.00 06000	LABORATORY	5,566	98,403	2,202,086	31	31 60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	1,260	45,808	532,391	6	9 65.00
66.00 06600	PHYSICAL THERAPY	8,910	16,348	1,347,286	18	29 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	333,632	3	0 67.00
68.00 06800	SPEECH PATHOLOGY	1,750	5,764	292,283	4	8 68.00
69.00 06900	ELECTROCARDIOLOGY	254	0	352,171	1	8 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	1,163	6,363	268,086	2	5 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,852	360	354,356	9	11 76.00
76.97 07697	CARDIAC REHABILITATION	0	0	413,286	1	0 76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	93,297	126,097	22,437,609	354	415 90.00
91.00 09100	EMERGENCY	14,029	28,816	4,653,975	39	31 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)					
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	3,665	823	690,391	13	14 101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	439,179	1,579,171	58,153,510	863	911 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	1,219	0	0	3	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	242,637	0	0 192.00
194.00 07950	MEALS ON WHEELS	0	0	0	0	0 194.00
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	4,553,612	1,639,299	17,138,888	830,592	5,169,723 202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	10.339765	1.038076	0.293493	959.113164	5,674.778266 203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			47,428	22,333	474,829 204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0012

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

Worksheet B-1

Date/Time Prepared:
5/30/2019 2:58 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (TELEPHONES)	DATA PROCESSING (NUMBER OF MACHINES)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00				
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000812	25.788684	521.217344	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0012

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

Worksheet B-1

Date/Time Prepared:
5/30/2019 2:58 pm

Cost Center Description		PURCHASING RECEIVING AND STORES (COST OF SUPPLIES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMIN & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		5.03	5.04	5A.05	5.05	7.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00590						5.02
5.03	00591						5.03
5.04	00580	12,977,281	436,039,383				5.04
5.05	00592	135,938	0	-10,501,288	93,879,778		5.05
7.00	00700	630,402	0	0	4,938,194	252,313	7.00
8.00	00800	0	0	0	298,853	177	8.00
9.00	00900	108,299	0	0	1,409,270	3,900	9.00
10.00	01000	8,725	0	0	530,757	5,415	10.00
11.00	01100	36,855	0	0	1,303,899	2,781	11.00
13.00	01300	42,753	0	0	2,386,600	2,570	13.00
14.00	01400	3,727,515	0	0	528,843	2,171	14.00
15.00	01500	20,954	0	0	1,744,738	2,566	15.00
16.00	01600	252,193	0	0	2,791,392	2,366	16.00
17.00	01700	0	0	0	100,654	0	17.00
17.01	01701	0	0	0	319,468	139	17.01
21.00	02100	0	0	0	1,021,648	0	21.00
22.00	02200	0	0	0	677,460	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	224,575	13,699,986	0	6,226,800	43,213	30.00
31.00	03100	73,241	7,798,890	0	1,925,649	4,438	31.00
40.00	04000	9,106	5,141,959	0	1,654,774	6,239	40.00
43.00	04300	66,546	1,036,061	0	687,112	416	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,087,622	45,408,224	0	5,409,030	27,158	50.00
52.00	05200	16,270	1,439,277	0	270,031	1,246	52.00
53.00	05300	79,388	6,343,601	0	192,572	85	53.00
54.00	05400	485,007	15,704,908	0	3,259,304	7,091	54.00
54.01	05401	41,373	8,152,716	0	740,529	284	54.01
57.00	05700	73,528	30,829,774	0	734,528	567	57.00
58.00	05800	146,070	9,820,753	0	587,966	496	58.00
59.00	05900	685,212	22,965,109	0	2,128,438	5,030	59.00
60.00	06000	1,547,813	44,992,935	0	6,508,288	5,566	60.00
64.00	06400	154,821	6,300,943	0	415,810	0	64.00
65.00	06500	204,195	9,188,827	0	1,206,629	1,260	65.00
66.00	06600	38,492	11,563,031	0	2,436,326	8,910	66.00
67.00	06700	14,979	1,748,105	0	489,486	0	67.00
68.00	06800	124,056	1,294,820	0	512,780	1,750	68.00
69.00	06900	19,869	10,011,941	0	743,075	254	69.00
70.00	07000	15,614	3,285,730	0	486,226	1,163	70.00
71.00	07100	0	30,797,836	0	1,907,374	0	71.00
72.00	07200	0	8,028,878	0	5,871,883	0	72.00
73.00	07300	0	47,796,642	0	2,663,195	0	73.00
76.00	03550	171	1,061,114	0	348,995	2,852	76.00
76.97	07697	1,525,149	720,460	0	816,830	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	1,129,196	65,141,084	0	20,525,974	93,297	90.00
91.00	09100	213,015	24,444,949	0	5,478,360	14,029	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	19,845	1,239,902	0	1,209,944	3,665	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		12,977,281	435,958,455	-10,501,288	93,489,684	251,094	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	21,736	1,219	190.00
192.00	19200	0	80,928	0	368,358	0	192.00
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00							201.00
202.00		1,504,413	6,113,953		10,501,288	5,490,575	202.00
203.00		0.115927	0.014022		0.111859	21.760968	203.00
204.00		343,815	88,943		212,497	1,582,867	204.00
205.00		0.026494	0.000204		0.002264	6.273426	205.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 14-0012		Period: From 01/01/2018 To 12/31/2018		Worksheet B-1 Date/Time Prepared: 5/30/2019 2:58 pm	
Cost Center Description		PURCHASING RECEIVING AND STORES (COST OF SUPPLIES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMIN & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		5.03	5.04	5A.05	5.05	7.00	
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0012

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

Worksheet B-1
Date/Time Prepared:
5/30/2019 2:58 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (HOURS OF SERVICE)	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00590						5.02
5.03	00591						5.03
5.04	00580						5.04
5.05	00592						5.05
7.00	00700						7.00
8.00	00800	377,297					8.00
9.00	00900	0	2,033				9.00
10.00	01000	0	12	53,336			10.00
11.00	01100	0	16	0	397		11.00
13.00	01300	0	10	0	8	793,645	13.00
14.00	01400	6,357	24	0	1	0	14.00
15.00	01500	0	26	0	11	0	15.00
16.00	01600	0	44	0	21	0	16.00
17.00	01700	0	0	0	0	0	17.00
17.01	01701	0	2	0	3	0	17.01
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	10	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	111,723	467	26,740	50	125,715	30.00
31.00	03100	20,696	58	3,610	13	35,564	31.00
40.00	04000	8,476	64	6,155	14	37,780	40.00
43.00	04300	5,172	12	0	3	11,999	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	84,125	400	1,337	37	67,212	50.00
52.00	05200	2,990	27	0	1	3,360	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	9,601	77	0	20	0	54.00
54.01	05401	5,063	4	0	4	0	54.01
57.00	05700	18,798	8	0	2	0	57.00
58.00	05800	6,007	7	0	3	0	58.00
59.00	05900	5,200	15	0	9	12,130	59.00
60.00	06000	0	68	0	30	0	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	73	0	6	18,018	65.00
66.00	06600	13,585	84	0	16	0	66.00
67.00	06700	0	27	0	4	0	67.00
68.00	06800	0	13	0	4	0	68.00
69.00	06900	0	15	0	7	9,874	69.00
70.00	07000	0	10	0	2	9,585	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
76.00	03550	0	13	0	6	12,030	76.00
76.97	07697	0	0	0	0	13,866	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	158	0	65	347,204	90.00
91.00	09100	79,504	264	0	36	65,609	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	20	0	11	23,699	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		377,297	2,018	37,842	397	793,645	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	15	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	15,494	0	0	194.00
200.00							200.00
201.00							201.00
202.00		336,134	1,651,778	717,713	1,523,269	2,748,310	202.00
203.00		0.890900	812.483030	13.456446	3,836.949622	3.462896	203.00
204.00		3,617	72,186	98,835	63,066	207,918	204.00
205.00		0.009587	35.507132	1.853064	158.856423	0.261979	205.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 14-0012			Period: From 01/01/2018 To 12/31/2018		Worksheet B-1 Date/Time Prepared: 5/30/2019 2:58 pm	
Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (HOURS OF SERVICE)		
		8.00	9.00	10.00	11.00	13.00		
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)							206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)							207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0012

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

Worksheet B-1
Date/Time Prepared:
5/30/2019 2:58 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUISITIONS)	PHARMACY (COSTED REQUISITIONS)	MEDICAL RECORDS & LIBRARY (I/P GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	UTILIZATION REVIEW (PATIENT DAYS)		
		14.00	15.00	16.00	17.00	17.01		
GENERAL SERVICE COST CENTERS								
1.00	00100						1.00	
2.00	00200						2.00	
4.00	00400						4.00	
5.01	00540						5.01	
5.02	00590						5.02	
5.03	00591						5.03	
5.04	00580						5.04	
5.05	00592						5.05	
7.00	00700						7.00	
8.00	00800						8.00	
9.00	00900						9.00	
10.00	01000						10.00	
11.00	01100						11.00	
13.00	01300						13.00	
14.00	01400	7,221,188					14.00	
15.00	01500		3,026,834				15.00	
16.00	01600			105,960,831			16.00	
17.00	01700				10,424		17.00	
17.01	01701					10,424	17.01	
21.00	02100						21.00	
22.00	02200						22.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000		5,012	10,686,322	6,344	6,344	30.00	
31.00	03100		1,232	7,798,890	1,508	1,508	31.00	
40.00	04000		154	5,141,959	2,015	2,015	40.00	
43.00	04300		403	1,036,061	557	557	43.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000		9,144	10,361,913			50.00	
52.00	05200		47	862,081			52.00	
53.00	05300			1,707,872			53.00	
54.00	05400		3,668	1,198,899			54.00	
54.01	05401		284	633,569			54.01	
57.00	05700		387	5,361,777			57.00	
58.00	05800		1,703	501,005			58.00	
59.00	05900		2,539	5,896,426			59.00	
60.00	06000		351	10,196,086			60.00	
64.00	06400		231,224	3,250,064			64.00	
65.00	06500		32,072	7,120,330			65.00	
66.00	06600		1	882,973			66.00	
67.00	06700			243,022			67.00	
68.00	06800			97,563			68.00	
69.00	06900			1,844,447			69.00	
70.00	07000			11,171			70.00	
71.00	07100	1,461,886		10,000,519			71.00	
72.00	07200	5,759,302		550,340			72.00	
73.00	07300		1,773,660	14,771,937			73.00	
76.00	03550		77	876,984			76.00	
76.97	07697						76.97	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000		945,549	17,545			90.00	
91.00	09100		19,248	4,911,076			91.00	
92.00	09200						92.00	
OTHER REIMBURSABLE COST CENTERS								
101.00	10100		79				101.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300						113.00	
118.00	SUBTOTALS (SUM OF LINES 1 through 117)						10,424	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000						190.00	
192.00	19200						192.00	
194.00	07950						194.00	
200.00	Cross Foot Adjustments						200.00	
201.00	Negative Cost Centers						201.00	
202.00		664,242	2,059,073	3,271,445	111,913	371,364	202.00	
203.00	Unit cost multiplier (Wkst. B, Part I)						203.00	
204.00		0.091985	0.680273	0.030874	10.736090	35.625863	204.00	
204.00	Cost to be allocated (per Wkst. B, Part II)						204.00	
205.00		138,655	237,751	86,706	288	5,915	205.00	
205.00	Unit cost multiplier (Wkst. B, Part II)						205.00	
205.00		0.019201	0.078548	0.000818	0.027629	0.567441	205.00	

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 14-0012			Period: From 01/01/2018 To 12/31/2018		Worksheet B-1 Date/Time Prepared: 5/30/2019 2:58 pm	
Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIREMENTS)	PHARMACY (COSTED REQUIREMENTS)	MEDICAL RECORDS & LIBRARY (I/P GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	UTILIZATION REVIEW (PATIENT DAYS)		
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)	14.00	15.00	16.00	17.00	17.01		206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)							207.00

Cost Center Description	INTERNS & RESIDENTS			
	SERVICES-SALARY & FRINGES A (PATIENT DAYS)	SERVICES-OTHER PRGM COSTS A (PATIENT DAYS)		
	21.00	22.00		
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
5.01 00540	NONPATIENT TELEPHONES			5.01
5.02 00590	DATA PROCESSING			5.02
5.03 00591	PURCHASING RECEIVING AND STORES			5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE			5.04
5.05 00592	OTHER ADMIN & GENERAL			5.05
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
17.01 01701	UTILIZATION REVIEW			17.01
21.00 02100	I&R SERVICES-SALARY & FRINGES A	8,409		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS A		8,409	22.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03000	ADULTS & PEDIATRICS	6,344	6,344	30.00
31.00 03100	INTENSIVE CARE UNIT	1,508	1,508	31.00
40.00 04000	SUBPROVIDER - I/PF	0	0	40.00
43.00 04300	NURSERY	557	557	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
54.01 05401	ULTRASOUND	0	0	54.01
57.00 05700	CT SCAN	0	0	57.00
58.00 05800	MRI	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000	LABORATORY	0	0	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.00
76.97 07697	CARDIAC REHABILITATION	0	0	76.97
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)			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)	8,409	8,409	118.00
NONREIMBURSABLE COST CENTERS				
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00 07950	MEALS ON WHEELS	0	0	194.00
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)	1,135,929	791,609	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	135.084909	94.138304	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	2,558	10,742	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0012

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

Worksheet B-1
Date/Time Prepared:
5/30/2019 2:58 pm

Cost Center Description		INTERNS & RESIDENTS		
		SERVICES-SALARY & FRINGES A (PATIENT DAYS)	SERVICES-OTHER PRGM COSTS A (PATIENT DAYS)	
		21.00	22.00	
205.00	Unit cost multiplier (Wkst. B, Part I)	0.304198	1.277441	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)			206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)			207.00

	Description	Worksheet		Amount		
		CODE	Line No.			
		1.00	2.00			
1.00	ADJ FOR EPO COSTS IN RENAL DIALYSIS		1	74.00	0	1.00
2.00	ADJ FOR EPO COSTS IN HOME PROGRAM		1	94.00	0	2.00
3.00	ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1	74.00	0	3.00
4.00	ADJ FOR ARANESP COSTS IN HOME PROGRAM		1	94.00	0	4.00
5.00	ADJ FOR ESA COSTS IN RENAL DIALYSIS		1	74.00	0	5.00
6.00	ADJ FOR ESA COSTS IN HOME PROGRAM		1	94.00	0	6.00
7.00	IV THERAPY & OP SERVICES		1	30.00	-81,715	7.00
8.00	IV THERAPY		1	64.00	1,208,909	8.00
9.00	IV THERAPY		1	50.00	-209,597	9.00
10.00	OUTPATIENT SERVICES		1	90.00	-557	10.00
11.00	IV THERAPY		1	91.00	-917,040	11.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0012

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

Worksheet C
Part I
Date/Time Prepared:
5/30/2019 2:58 pm

		Title XVIII		Hospital		PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		9,875,399	0	9,875,399	30.00
31.00	03100 INTENSIVE CARE UNIT		2,836,334	0	2,836,334	31.00
40.00	04000 SUBPROVIDER - IPF		2,554,838	0	2,554,838	40.00
43.00	04300 NURSERY		898,530	0	898,530	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		7,514,246	0	7,514,246	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		394,071	0	394,071	52.00
53.00	05300 ANESTHESIOLOGY		268,692	0	268,692	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		3,965,557	0	3,965,557	54.00
54.01	05401 ULTRASOUND		872,407	0	872,407	54.01
57.00	05700 CT SCAN		1,025,754	0	1,025,754	57.00
58.00	05800 MRI		703,705	0	703,705	58.00
59.00	05900 CARDIAC CATHETERIZATION		2,753,112	0	2,753,112	59.00
60.00	06000 LABORATORY		7,842,811	12,923	7,855,734	60.00
64.00	06400 INTRAVENOUS THERAPY		1,928,868	0	1,928,868	64.00
65.00	06500 RESPIRATORY THERAPY	0	1,755,398	0	1,755,398	65.00
66.00	06600 PHYSICAL THERAPY	0	3,071,746	0	3,071,746	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	589,027	0	589,027	67.00
68.00	06800 SPEECH PATHOLOGY	0	637,143	0	637,143	68.00
69.00	06900 ELECTROCARDIOLOGY		961,906	0	961,906	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		615,259	0	615,259	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT		2,563,959	0	2,563,959	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		7,075,467	0	7,075,467	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		4,623,748	0	4,623,748	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		552,466	0	552,466	76.00
76.97	07697 CARDIAC REHABILITATION		956,217	0	956,217	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		27,075,532	32,175	27,107,707	90.00
91.00	09100 EMERGENCY		6,294,781	1,485,648	7,780,429	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)		2,429,538		2,429,538	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY		1,565,618		1,565,618	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		104,202,129	0	104,202,129	200.00
201.00	Less Observation Beds		2,429,538		2,429,538	201.00
202.00	Total (see instructions)		101,772,591	0	101,772,591	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0012		Period: From 01/01/2018 To 12/31/2018		Worksheet C Part I Date/Time Prepared: 5/30/2019 2:58 pm		
			Title XVIII			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	10,387,625		10,387,625				30.00
31.00	03100	INTENSIVE CARE UNIT	7,798,890		7,798,890				31.00
40.00	04000	SUBPROVIDER - IPF	5,141,959		5,141,959				40.00
43.00	04300	NURSERY	1,036,061		1,036,061				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	10,361,913	35,046,311	45,408,224	0.165482	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	862,081	577,196	1,439,277	0.273798	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	1,707,872	4,635,729	6,343,601	0.042356	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,198,899	14,506,009	15,704,908	0.252504	0.000000		54.00
54.01	05401	ULTRASOUND	633,569	7,519,147	8,152,716	0.107008	0.000000		54.01
57.00	05700	CT SCAN	5,361,777	25,467,997	30,829,774	0.033272	0.000000		57.00
58.00	05800	MRI	501,005	9,319,748	9,820,753	0.071655	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	5,896,426	17,068,683	22,965,109	0.119882	0.000000		59.00
60.00	06000	LABORATORY	10,196,086	34,796,849	44,992,935	0.174312	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	3,250,064	3,050,879	6,300,943	0.306124	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	7,120,330	2,068,497	9,188,827	0.191036	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	882,973	10,680,058	11,563,031	0.265652	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	243,022	1,505,083	1,748,105	0.336952	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	97,563	1,197,257	1,294,820	0.492071	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	1,844,447	8,167,494	10,011,941	0.096076	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	11,171	3,274,559	3,285,730	0.187252	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	10,000,519	20,797,317	30,797,836	0.083251	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	550,340	7,478,538	8,028,878	0.881252	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,771,937	33,024,705	47,796,642	0.096738	0.000000		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	876,984	184,130	1,061,114	0.520647	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0	720,460	720,460	1.327231	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	17,545	39,067,105	39,084,650	0.692741	0.000000		90.00
91.00	09100	EMERGENCY	4,911,076	19,533,873	24,444,949	0.257508	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	298,697	3,013,664	3,312,361	0.733476	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
101.00	10100	HOME HEALTH AGENCY	0	1,239,902	1,239,902				101.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	105,960,831	303,941,190	409,902,021				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	105,960,831	303,941,190	409,902,021				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0012	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/30/2019 2:58 pm
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.165482		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.273798		52.00
53.00	05300 ANESTHESIOLOGY	0.042356		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.252504		54.00
54.01	05401 ULTRASOUND	0.107008		54.01
57.00	05700 CT SCAN	0.033272		57.00
58.00	05800 MRI	0.071655		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.119882		59.00
60.00	06000 LABORATORY	0.174599		60.00
64.00	06400 INTRAVENOUS THERAPY	0.306124		64.00
65.00	06500 RESPIRATORY THERAPY	0.191036		65.00
66.00	06600 PHYSICAL THERAPY	0.265652		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.336952		67.00
68.00	06800 SPEECH PATHOLOGY	0.492071		68.00
69.00	06900 ELECTROCARDIOLOGY	0.096076		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.187252		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.083251		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.881252		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.096738		73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.520647		76.00
76.97	07697 CARDIAC REHABILITATION	1.327231		76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.693564		90.00
91.00	09100 EMERGENCY	0.318284		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	0.733476		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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0012

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

Worksheet C
Part I
Date/Time Prepared:
5/30/2019 2:58 pm

		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		9,875,399	0	9,875,399	30.00
31.00	03100 INTENSIVE CARE UNIT		2,836,334	0	2,836,334	31.00
40.00	04000 SUBPROVIDER - IPF		2,554,838	0	2,554,838	40.00
43.00	04300 NURSERY		898,530	0	898,530	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		7,514,246	0	7,514,246	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		394,071	0	394,071	52.00
53.00	05300 ANESTHESIOLOGY		268,692	0	268,692	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		3,965,557	0	3,965,557	54.00
54.01	05401 ULTRASOUND		872,407	0	872,407	54.01
57.00	05700 CT SCAN		1,025,754	0	1,025,754	57.00
58.00	05800 MRI		703,705	0	703,705	58.00
59.00	05900 CARDIAC CATHETERIZATION		2,753,112	0	2,753,112	59.00
60.00	06000 LABORATORY		7,842,811	12,923	7,855,734	60.00
64.00	06400 INTRAVENOUS THERAPY		1,928,868	0	1,928,868	64.00
65.00	06500 RESPIRATORY THERAPY	0	1,755,398	0	1,755,398	65.00
66.00	06600 PHYSICAL THERAPY	0	3,071,746	0	3,071,746	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	589,027	0	589,027	67.00
68.00	06800 SPEECH PATHOLOGY	0	637,143	0	637,143	68.00
69.00	06900 ELECTROCARDIOLOGY		961,906	0	961,906	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		615,259	0	615,259	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT		2,563,959	0	2,563,959	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		7,075,467	0	7,075,467	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		4,623,748	0	4,623,748	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		552,466	0	552,466	76.00
76.97	07697 CARDIAC REHABILITATION		956,217	0	956,217	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		27,075,532	32,175	27,107,707	90.00
91.00	09100 EMERGENCY		6,294,781	1,485,648	7,780,429	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)		2,429,538		2,429,538	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY		1,565,618		1,565,618	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		104,202,129	0	104,202,129	200.00
201.00	Less Observation Beds		2,429,538		2,429,538	201.00
202.00	Total (see instructions)		101,772,591	0	101,772,591	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0012		Period: From 01/01/2018 To 12/31/2018		Worksheet C Part I Date/Time Prepared: 5/30/2019 2:58 pm		
			Title XIX			Hospital		Cost	
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	10,387,625		10,387,625				30.00
31.00	03100	INTENSIVE CARE UNIT	7,798,890		7,798,890				31.00
40.00	04000	SUBPROVIDER - IPF	5,141,959		5,141,959				40.00
43.00	04300	NURSERY	1,036,061		1,036,061				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	10,361,913	35,046,311	45,408,224	0.165482	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	862,081	577,196	1,439,277	0.273798	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	1,707,872	4,635,729	6,343,601	0.042356	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,198,899	14,506,009	15,704,908	0.252504	0.000000		54.00
54.01	05401	ULTRASOUND	633,569	7,519,147	8,152,716	0.107008	0.000000		54.01
57.00	05700	CT SCAN	5,361,777	25,467,997	30,829,774	0.033272	0.000000		57.00
58.00	05800	MRI	501,005	9,319,748	9,820,753	0.071655	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	5,896,426	17,068,683	22,965,109	0.119882	0.000000		59.00
60.00	06000	LABORATORY	10,196,086	34,796,849	44,992,935	0.174312	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	3,250,064	3,050,879	6,300,943	0.306124	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	7,120,330	2,068,497	9,188,827	0.191036	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	882,973	10,680,058	11,563,031	0.265652	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	243,022	1,505,083	1,748,105	0.336952	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	97,563	1,197,257	1,294,820	0.492071	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	1,844,447	8,167,494	10,011,941	0.096076	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	11,171	3,274,559	3,285,730	0.187252	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	10,000,519	20,797,317	30,797,836	0.083251	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	550,340	7,478,538	8,028,878	0.881252	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,771,937	33,024,705	47,796,642	0.096738	0.000000		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	876,984	184,130	1,061,114	0.520647	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0	720,460	720,460	1.327231	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	17,545	39,067,105	39,084,650	0.692741	0.000000		90.00
91.00	09100	EMERGENCY	4,911,076	19,533,873	24,444,949	0.257508	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	298,697	3,013,664	3,312,361	0.733476	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
101.00	10100	HOME HEALTH AGENCY	0	1,239,902	1,239,902				101.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	105,960,831	303,941,190	409,902,021				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	105,960,831	303,941,190	409,902,021				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0012	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/30/2019 2:58 pm
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401 ULTRASOUND	0.000000		54.01
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000		76.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	0.000000		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: 14-0012		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part I Date/Time Prepared: 5/30/2019 2:58 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	961,647	0	961,647	8,414	114.29	30.00
31.00	INTENSIVE CARE UNIT	154,212	0	154,212	1,508	102.26	31.00
40.00	SUBPROVIDER - IPF	148,909	0	148,909	2,015	73.90	40.00
43.00	NURSERY	23,564		23,564	557	42.31	43.00
200.00	Total (lines 30 through 199)	1,288,332		1,288,332	12,494		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	3,356	383,557				
31.00	INTENSIVE CARE UNIT	512	52,357				
40.00	SUBPROVIDER - IPF	491	36,285				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	4,359	472,199				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0012	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Prepared: 5/30/2019 2:58 pm
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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)	Hospital Inpatient Program Charges	PPS 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	1,197,493	45,408,224	0.026372	3,476,476	91,682	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	31,045	1,439,277	0.021570	0	0	52.00
53.00	05300 ANESTHESIOLOGY	25,672	6,343,601	0.004047	582,982	2,359	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	279,741	15,704,908	0.017812	715,822	12,750	54.00
54.01	05401 ULTRASOUND	91,996	8,152,716	0.011284	293,779	3,315	54.01
57.00	05700 CT SCAN	54,522	30,829,774	0.001768	2,866,340	5,068	57.00
58.00	05800 MRI	25,931	9,820,753	0.002640	260,118	687	58.00
59.00	05900 CARDIAC CATHETERIZATION	245,908	22,965,109	0.010708	2,025,957	21,694	59.00
60.00	06000 LABORATORY	370,358	44,992,935	0.008231	4,982,153	41,008	60.00
64.00	06400 INTRAVENOUS THERAPY	27,149	6,300,943	0.004309	25,222	109	64.00
65.00	06500 RESPIRATORY THERAPY	100,816	9,188,827	0.010972	3,083,007	33,827	65.00
66.00	06600 PHYSICAL THERAPY	226,713	11,563,031	0.019607	557,800	10,937	66.00
67.00	06700 OCCUPATIONAL THERAPY	4,003	1,748,105	0.002290	149,825	343	67.00
68.00	06800 SPEECH PATHOLOGY	45,455	1,294,820	0.035105	67,187	2,359	68.00
69.00	06900 ELECTROCARDIOLOGY	18,692	10,011,941	0.001867	1,669,389	3,117	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	34,180	3,285,730	0.010403	8,676	90	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	46,851	30,797,836	0.001521	6,114,229	9,300	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	125,967	8,028,878	0.015689	550,340	8,634	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	167,214	47,796,642	0.003498	8,196,128	28,670	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	60,309	1,061,114	0.056836	4,083	232	76.00
76.97	07697 CARDIAC REHABILITATION	260,082	720,460	0.360994	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	2,482,459	39,084,650	0.063515	16,541	1,051	90.00
91.00	09100 EMERGENCY	345,529	24,444,949	0.014135	2,642,702	37,355	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	236,584	3,312,361	0.071425	289,542	20,681	92.00
200.00	Total (lines 50 through 199)	6,504,669	384,297,584		38,578,298	335,268	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0012	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part III Date/Time Prepared: 5/30/2019 2:58 pm
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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	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
			4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	8,414	0.00	3,356	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	1,508	0.00	512	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	2,015	0.00	491	40.00	
43.00	04300	NURSERY		0	557	0.00	0	43.00	
200.00		Total (lines 30 through 199)		0	12,494		4,359	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
40.00	04000	SUBPROVIDER - IPF	0						40.00
43.00	04300	NURSERY	0						43.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0012	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/30/2019 2:58 pm
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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	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0012	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/30/2019 2:58 pm
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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	45,408,224	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,439,277	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	6,343,601	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	15,704,908	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	8,152,716	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	30,829,774	0.000000	57.00
58.00	05800	MRI	0	0	0	9,820,753	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	22,965,109	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	44,992,935	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	6,300,943	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	9,188,827	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	11,563,031	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,748,105	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,294,820	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	10,011,941	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	3,285,730	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	30,797,836	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	8,028,878	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	47,796,642	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	1,061,114	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	720,460	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	39,084,650	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	24,444,949	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	3,312,361	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	384,297,584		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0012	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/30/2019 2:58 pm
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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	3,476,476	0	8,386,741	0	50.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00	
53.00	05300 ANESTHESIOLOGY	0.000000	582,982	0	1,022,959	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	715,822	0	4,757,442	0	54.00	
54.01	05401 ULTRASOUND	0.000000	293,779	0	1,411,499	0	54.01	
57.00	05700 CT SCAN	0.000000	2,866,340	0	7,962,725	0	57.00	
58.00	05800 MRI	0.000000	260,118	0	2,345,524	0	58.00	
59.00	05900 CARDIAC CATHETERIZATION	0.000000	2,025,957	0	7,775,755	0	59.00	
60.00	06000 LABORATORY	0.000000	4,982,153	0	5,041,245	0	60.00	
64.00	06400 INTRAVENOUS THERAPY	0.000000	25,222	0	1,152,702	0	64.00	
65.00	06500 RESPIRATORY THERAPY	0.000000	3,083,007	0	1,345,667	0	65.00	
66.00	06600 PHYSICAL THERAPY	0.000000	557,800	0	44,347	0	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0.000000	149,825	0	9,360	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0.000000	67,187	0	71,643	0	68.00	
69.00	06900 ELECTROCARDIOLOGY	0.000000	1,669,389	0	3,465,574	0	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	8,676	0	886,975	0	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.000000	6,114,229	0	5,294,821	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	550,340	0	2,653,071	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	8,196,128	0	9,329,417	0	73.00	
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	4,083	0	40,832	0	76.00	
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	335,542	0	76.97	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000 CLINIC	0.000000	16,541	0	3,245,290	0	90.00	
91.00	09100 EMERGENCY	0.000000	2,642,702	0	4,517,044	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0.000000	289,542	0	759,481	0	92.00	
200.00	Total (lines 50 through 199)		38,578,298	0	71,855,656	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0012	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/30/2019 2:58 pm
		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	0.165482	8,386,741	0	0	1,387,855	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.273798	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.042356	1,022,959	0	0	43,328	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.252504	4,757,442	0	0	1,201,273	54.00
54.01	05401	ULTRASOUND	0.107008	1,411,499	0	0	151,042	54.01
57.00	05700	CT SCAN	0.033272	7,962,725	0	0	264,936	57.00
58.00	05800	MRI	0.071655	2,345,524	0	0	168,069	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.119882	7,775,755	0	0	932,173	59.00
60.00	06000	LABORATORY	0.174312	5,041,245	0	0	878,749	60.00
64.00	06400	INTRAVENOUS THERAPY	0.306124	1,152,702	0	13	352,870	64.00
65.00	06500	RESPIRATORY THERAPY	0.191036	1,345,667	0	0	257,071	65.00
66.00	06600	PHYSICAL THERAPY	0.265652	44,347	0	0	11,781	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.336952	9,360	0	0	3,154	67.00
68.00	06800	SPEECH PATHOLOGY	0.492071	71,643	0	0	35,253	68.00
69.00	06900	ELECTROCARDIOLOGY	0.096076	3,465,574	0	0	332,958	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.187252	886,975	0	0	166,088	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.083251	5,294,821	0	0	440,799	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.881252	2,653,071	0	0	2,338,024	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.096738	9,329,417	2,424	141,823	902,509	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.520647	40,832	0	0	21,259	76.00
76.97	07697	CARDIAC REHABILITATION	1.327231	335,542	0	0	445,342	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.692741	3,245,290	0	346	2,248,145	90.00
91.00	09100	EMERGENCY	0.257508	4,517,044	0	108	1,163,175	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0.733476	759,481	0	0	557,061	92.00
200.00		Subtotal (see instructions)		71,855,656	2,424	142,290	14,302,914	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		71,855,656	2,424	142,290	14,302,914	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0012	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/30/2019 2:58 pm
	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
54.01	05401 ULTRASOUND	0	0	54.01
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MRI	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	4	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	234	13,720	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	240	90.00
91.00	09100 EMERGENCY	0	28	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0	0	92.00
200.00	Subtotal (see instructions)	234	13,992	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	234	13,992	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 14-0012 Component CCN: 14-S012		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part II Date/Time Prepared: 5/30/2019 2:58 pm	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,197,493	45,408,224	0.026372	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	31,045	1,439,277	0.021570	0	0	52.00
53.00	05300	ANESTHESIOLOGY	25,672	6,343,601	0.004047	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	279,741	15,704,908	0.017812	3,192	57	54.00
54.01	05401	ULTRASOUND	91,996	8,152,716	0.011284	3,173	36	54.01
57.00	05700	CT SCAN	54,522	30,829,774	0.001768	11,305	20	57.00
58.00	05800	MRI	25,931	9,820,753	0.002640	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	245,908	22,965,109	0.010708	0	0	59.00
60.00	06000	LABORATORY	370,358	44,992,935	0.008231	249,791	2,056	60.00
64.00	06400	INTRAVENOUS THERAPY	27,149	6,300,943	0.004309	4,091	18	64.00
65.00	06500	RESPIRATORY THERAPY	100,816	9,188,827	0.010972	22,431	246	65.00
66.00	06600	PHYSICAL THERAPY	226,713	11,563,031	0.019607	4,115	81	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,003	1,748,105	0.002290	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	45,455	1,294,820	0.035105	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	18,692	10,011,941	0.001867	5,760	11	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	34,180	3,285,730	0.010403	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	46,851	30,797,836	0.001521	9,857	15	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	125,967	8,028,878	0.015689	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	167,214	47,796,642	0.003498	264,979	927	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	60,309	1,061,114	0.056836	22,705	1,290	76.00
76.97	07697	CARDIAC REHABILITATION	260,082	720,460	0.360994	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,482,459	39,084,650	0.063515	1,004	64	90.00
91.00	09100	EMERGENCY	345,529	24,444,949	0.014135	205,499	2,905	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	3,312,361	0.000000	9,155	0	92.00
200.00		Total (lines 50 through 199)	6,268,085	384,297,584		817,057	7,726	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0012 Component CCN: 14-S012	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/30/2019 2:58 pm
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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
54.01	05401 ULTRASOUND	0	0	0	0	0	54.01
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	0	92.00
200.00	Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0012 Component CCN: 14-S012	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/30/2019 2:58 pm
Title XVIII		Subprovider - IPF	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	45,408,224	0.000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	1,439,277	0.000000	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	6,343,601	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	15,704,908	0.000000	54.00
54.01 05401 ULTRASOUND	0	0	0	8,152,716	0.000000	54.01
57.00 05700 CT SCAN	0	0	0	30,829,774	0.000000	57.00
58.00 05800 MRI	0	0	0	9,820,753	0.000000	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	22,965,109	0.000000	59.00
60.00 06000 LABORATORY	0	0	0	44,992,935	0.000000	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	6,300,943	0.000000	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	9,188,827	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	11,563,031	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	1,748,105	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	1,294,820	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	10,011,941	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	3,285,730	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	30,797,836	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	8,028,878	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	47,796,642	0.000000	73.00
76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	1,061,114	0.000000	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	720,460	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	39,084,650	0.000000	90.00
91.00 09100 EMERGENCY	0	0	0	24,444,949	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0	0	0	3,312,361	0.000000	92.00
200.00 Total (lines 50 through 199)	0	0	0	384,297,584		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0012 Component CCN: 14-S012	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/30/2019 2:58 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	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	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	3,192	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	3,173	0	0	0	54.01
57.00	05700	CT SCAN	0.000000	11,305	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	249,791	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	4,091	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	22,431	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	4,115	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	5,760	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	9,857	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	264,979	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	22,705	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	1,004	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	205,499	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0.000000	9,155	0	0	0	92.00
200.00		Total (lines 50 through 199)		817,057	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0012	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/30/2019 2:58 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		8,414	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		8,414	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)		6,344	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)		3,356	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)		9,875,399	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)		9,875,399	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)		9,875,399	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,173.69	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,938,904	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		3,938,904	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0012	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/30/2019 2:58 pm		
Cost Center Description			Title XVIII		Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	2,836,334	1,508	1,880.86	512	963,000	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)					5,883,341	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					10,785,245	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)					435,914	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					335,268	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					771,182	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					10,014,063	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					2,070	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,173.69	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,429,538	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0012		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/30/2019 2:58 pm	
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	961,647	9,875,399	0.097378	2,429,538	236,584	90.00
91.00	Nursing School cost	0	9,875,399	0.000000	2,429,538	0	91.00
92.00	Allied health cost	0	9,875,399	0.000000	2,429,538	0	92.00
93.00	All other Medical Education	0	9,875,399	0.000000	2,429,538	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0012 Component CCN: 14-S012	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/30/2019 2:58 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,015	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,015	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)		2,015	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)		491	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)		2,554,838	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)		2,554,838	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)		2,554,838	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,267.91	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		622,544	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)		622,544	41.00

COMPUTATION OF INPATIENT OPERATING COST					Provider CCN: 14-0012	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1
					Component CCN: 14-S012		Date/Time Prepared: 5/30/2019 2:58 pm
					Title XVIII	Subprovider - IPF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00	
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00	
44.00 CORONARY CARE UNIT						44.00	
45.00 BURN INTENSIVE CARE UNIT						45.00	
46.00 SURGICAL INTENSIVE CARE UNIT						46.00	
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00	
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					163,412	48.00	
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					785,956	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)					36,285	50.00	
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					7,726	51.00	
52.00 Total Program excludable cost (sum of lines 50 and 51)					44,011	52.00	
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					741,945	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: 14-0012 Component CCN: 14-S012		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/30/2019 2:58 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	148,909	2,554,838	0.058285	0	0	90.00
91.00	Nursing School cost	0	2,554,838	0.000000	0	0	91.00
92.00	Allied health cost	0	2,554,838	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,554,838	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0012	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/30/2019 2:58 pm	
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		7,721,760	30.00
31.00	03100	INTENSIVE CARE UNIT		2,227,712	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.165482	3,476,476	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.273798	0	52.00
53.00	05300	ANESTHESIOLOGY	0.042356	582,982	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.252504	715,822	54.00
54.01	05401	ULTRASOUND	0.107008	293,779	54.01
57.00	05700	CT SCAN	0.033272	2,866,340	57.00
58.00	05800	MRI	0.071655	260,118	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.119882	2,025,957	59.00
60.00	06000	LABORATORY	0.174599	4,982,153	60.00
64.00	06400	INTRAVENOUS THERAPY	0.306124	25,222	64.00
65.00	06500	RESPIRATORY THERAPY	0.191036	3,083,007	65.00
66.00	06600	PHYSICAL THERAPY	0.265652	557,800	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.336952	149,825	67.00
68.00	06800	SPEECH PATHOLOGY	0.492071	67,187	68.00
69.00	06900	ELECTROCARDIOLOGY	0.096076	1,669,389	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.187252	8,676	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.083251	6,114,229	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.881252	550,340	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.096738	8,196,128	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.520647	4,083	76.00
76.97	07697	CARDIAC REHABILITATION	1.327231	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.693564	16,541	90.00
91.00	09100	EMERGENCY	0.318284	2,642,702	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.733476	289,542	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		38,578,298	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)		38,578,298	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0012 Component CCN: 14-S012	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/30/2019 2:58 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		1,252,271		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.165482	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.273798	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.042356	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.252504	3,192	806	54.00
54.01	05401 ULTRASOUND	0.107008	3,173	340	54.01
57.00	05700 CT SCAN	0.033272	11,305	376	57.00
58.00	05800 MRI	0.071655	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.119882	0	0	59.00
60.00	06000 LABORATORY	0.174599	249,791	43,613	60.00
64.00	06400 INTRAVENOUS THERAPY	0.306124	4,091	1,252	64.00
65.00	06500 RESPIRATORY THERAPY	0.191036	22,431	4,285	65.00
66.00	06600 PHYSICAL THERAPY	0.265652	4,115	1,093	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.336952	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.492071	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.096076	5,760	553	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.187252	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.083251	9,857	821	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.881252	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.096738	264,979	25,634	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.520647	22,705	11,821	76.00
76.97	07697 CARDIAC REHABILITATION	1.327231	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.693564	1,004	696	90.00
91.00	09100 EMERGENCY	0.318284	205,499	65,407	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0.733476	9,155	6,715	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		817,057	163,412	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)		817,057		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0012	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/30/2019 2:58 pm
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		6,551,170	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		2,183,724	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)		49,715	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		1,464,738	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		60.33	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)		6.00	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)		6.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		4.22	10.00
11.00	FTE count for residents in dental and podiatric programs.		3.17	11.00
12.00	Current year allowable FTE (see instructions)		7.39	12.00
13.00	Total allowable FTE count for the prior year.		7.05	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.		6.27	14.00
15.00	Sum of lines 12 through 14 divided by 3.		6.90	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		6.90	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.114371	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.111222	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.111222	21.00
22.00	IME payment adjustment (see instructions)		514,573	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		86,288	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)		-1.78	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)		514,573	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		86,288	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.34	30.00
31.00	Percentage of Medicaid patient days (see instructions)		18.25	31.00
32.00	Sum of lines 30 and 31		20.59	32.00
33.00	Allowable disproportionate share percentage (see instructions)		6.20	33.00
34.00	Disproportionate share adjustment (see instructions)		135,391	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0012	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/30/2019 2:58 pm
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)	6,766,695,164	8,272,872,447	35.00
35.01	Factor 3 (see instructions)	0.000099914	0.000157597	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	676,089	1,303,782	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	505,677	328,625	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	834,302		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)	10,268,875		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)		10,355,163	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		782,105	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).		157,254	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see 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)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		11,294,522	59.00
60.00	Primary payer payments		2,309	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		11,292,213	61.00
62.00	Deductibles billed to program beneficiaries		1,179,032	62.00
63.00	Coinurance billed to program beneficiaries		4,020	63.00
64.00	Allowable bad debts (see instructions)		144,100	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		93,665	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		109,353	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		10,202,826	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)		58,598	70.93
70.94	HRR adjustment amount (see instructions)		-397	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0012	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/30/2019 2:58 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		110,076	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		10,150,951	71.00
71.01	Sequestration adjustment (see instructions)		203,019	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		9,971,306	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)		-23,374	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
			Prior to 10/1	On/After 10/1
			1.00	2.00
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0012	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/30/2019 2:58 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		14,226	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		14,302,914	2.00
3.00	OPPS payments		13,309,677	3.00
4.00	Outlier payment (see instructions)		39,333	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		14,226	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		144,714	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)		144,714	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		144,715	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)		130,468	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		1.000000	17.00
18.00	Total customary charges (see instructions)		144,714	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		130,488	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)		14,226	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)		13,349,010	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)		2,774,590	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)		10,588,646	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		194,604	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)		10,783,250	30.00
31.00	Primary payer payments		487	31.00
32.00	Subtotal (line 30 minus line 31)		10,782,763	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)		55,483	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		36,064	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		36,299	36.00
37.00	Subtotal (see instructions)		10,818,827	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-57	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)		10,818,884	40.00
40.01	Sequestration adjustment (see instructions)		216,378	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		10,597,197	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		5,309	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: 14-0012

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

Worksheet E-1
Part I
Date/Time Prepared:
5/30/2019 2:58 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		9,971,306		10,597,197	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		9,971,306		10,597,197	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		5,309	6.01	
6.02	SETTLEMENT TO PROGRAM		23,374		0	6.02	
7.00	Total Medicare program liability (see instructions)		9,947,932		10,602,506	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: 14-0012
Component CCN: 14-S012

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

Worksheet E-1
Part I
Date/Time Prepared:
5/30/2019 2:58 pm

Title XVIII

Subprovider -
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		359,060		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		359,060		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		45		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		359,105		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: 14-0012	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/30/2019 2:58 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0012 Component CCN: 14-S012	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part II Date/Time Prepared: 5/30/2019 2:58 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			468,537 1.00
2.00	Net IPF PPS Outlier Payments			0 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			5.520548 9.00
10.00	Teaching Adjustment Factor $\{(1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			468,537 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			468,537 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			468,537 18.00
19.00	Deductibles			101,768 19.00
20.00	Subtotal (line 18 minus line 19)			366,769 20.00
21.00	Coinurance			335 21.00
22.00	Subtotal (line 20 minus line 21)			366,434 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			0 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 25.00
26.00	Subtotal (sum of lines 22 and 24)			366,434 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			366,434 31.00
31.01	Sequestration adjustment (see instructions)			7,329 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			359,060 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			45 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0 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

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0012	Period: From 01/01/2018 To 12/31/2018	Worksheet E-4 Date/Time Prepared: 5/30/2019 2:58 pm	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			6.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			6.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			4.22	6.00
7.00	Enter the lesser of line 5 or line 6			4.22	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	4.22	0.00	4.22	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	4.22	0.00	4.22	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		3.17		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	4.22	3.17		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	3.64	3.22		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	3.38	2.89		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	3.75	3.09		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	3.75	3.09		17.00
18.00	Per resident amount	103,690.40	103,690.40		18.00
19.00	Approved amount for resident costs	388,839	320,403	709,242	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			709,242	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	4,359	652		26.00
27.00	Total Inpatient Days (see instructions)	9,915	9,915		27.00
28.00	Ratio of inpatient days to total inpatient days	0.439637	0.065759		28.00
29.00	Program direct GME amount	311,809	46,639		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		6,590		30.00
31.00	Net Program direct GME amount			351,858	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0012	Period: From 01/01/2018 To 12/31/2018	Worksheet E-4 Date/Time Prepared: 5/30/2019 2:58 pm
		Title XVIII	Hospital	PPS
				1.00
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		11,571,201	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		2,309	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		11,568,892	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		14,317,140	42.00
43.00	Primary payer payments (see instructions)		487	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		14,316,653	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		25,885,545	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.446925	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.553075	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		351,858	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		157,254	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		194,604	50.00

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

Provider CCN: 14-0012

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

Worksheet G
Date/Time Prepared:
5/30/2019 2:58 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	19,083,284	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	33,945,807	0	0	0	4.00
5.00	Other receivable	3,029,677	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,374,044	0	0	0	7.00
8.00	Prepaid expenses	1,313,789	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	58,746,601	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,343,039	0	0	0	12.00
13.00	Land improvements	5,510,345	0	0	0	13.00
14.00	Accumulated depreciation	-3,543,618	0	0	0	14.00
15.00	Buildings	51,011,302	0	0	0	15.00
16.00	Accumulated depreciation	-31,205,570	0	0	0	16.00
17.00	Leasehold improvements	19,000	0	0	0	17.00
18.00	Accumulated depreciation	-19,000	0	0	0	18.00
19.00	Fixed equipment	32,859,006	0	0	0	19.00
20.00	Accumulated depreciation	-21,740,778	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	38,810,514	0	0	0	23.00
24.00	Accumulated depreciation	-32,248,047	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	6,109,812	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	47,906,005	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	29,304,924	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	29,304,924	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	135,957,530	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	9,081,030	0	0	0	37.00
38.00	Salaries, wages, and fees payable	8,446,156	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,491,745	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	961,580	0	0	0	43.00
44.00	Other current liabilities	1,345,799	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	21,326,310	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	21,850,121	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	17,361,762	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	39,211,883	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	60,538,193	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	75,419,337				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)	75,419,337	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	135,957,530	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0012

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

Worksheet G-1

Date/Time Prepared:
5/30/2019 2:58 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		72,517,360		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		3,200,976			2.00
3.00	Total (sum of line 1 and line 2)		75,718,336		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)		75,718,336		0	11.00
12.00	DECREASE IN RESTRICTED ASSETS	298,999		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)		298,999		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		75,419,337		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	DECREASE IN RESTRICTED ASSETS		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: 14-0012

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/30/2019 2:58 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	11,423,686		11,423,686	1.00
2.00	SUBPROVIDER - IPF	5,141,959		5,141,959	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	16,565,645		16,565,645	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	7,798,890		7,798,890	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)	7,798,890		7,798,890	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	24,364,535		24,364,535	17.00
18.00	Ancillary services	76,353,489	241,102,135	317,455,624	18.00
19.00	Outpatient services	4,928,621	58,600,978	63,529,599	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		1,239,902	1,239,902	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIANS' PRIVATE OFFICES	0	44,465,370	44,465,370	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	105,646,645	345,408,385	451,055,030	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		135,057,499		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)		135,057,499		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0012

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

Worksheet G-3

Date/Time Prepared:
5/30/2019 2:58 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	451,055,030	1.00
2.00	Less contractual allowances and discounts on patients' accounts	319,983,772	2.00
3.00	Net patient revenues (line 1 minus line 2)	131,071,258	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	135,057,499	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,986,241	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	596,014	6.00
7.00	Income from investments	-52,429	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	8,279	10.00
11.00	Rebates and refunds of expenses	29,106	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	403,890	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	18,948	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	48,580	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	5,420	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	431,497	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC INCOME	113,222	24.00
24.01	RETAIL PHARMACY	5,156,898	24.01
24.02	GAIN ON DISPOSAL OF ASSETS	5,692	24.02
24.03	MEALS ON WHEELS	47,571	24.03
24.04	INTEREST INCOME ON PATIENT ACCOUNTS	374,529	24.04
25.00	Total other income (sum of lines 6-24)	7,187,217	25.00
26.00	Total (line 5 plus line 25)	3,200,976	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	3,200,976	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0012

Period: From 01/01/2018

Worksheet H

HHA CCN: 14-7131

To 12/31/2018

Date/Time Prepared: 5/30/2019 2:58 pm

Home Health Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col.s. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00			0		0	0	1.00
2.00			0		0	0	2.00
3.00	0	0	0	0	0	0	3.00
4.00	0	0	0	0	0	0	4.00
5.00	246,691	11,983	0	29,275	53,568	341,517	5.00
HHA REIMBURSABLE SERVICES							
6.00	251,355	12,209	12,128	0	0	275,692	6.00
7.00	0	0	13,163	0	0	13,163	7.00
8.00	0	0	2,119	0	0	2,119	8.00
9.00	0	0	363	0	0	363	9.00
10.00	178,470	8,669	16	0	0	187,155	10.00
11.00	13,875	674	2,886	0	0	17,435	11.00
12.00	0	0	0	0	17,832	17,832	12.00
13.00	0	0	0	0	0	0	13.00
14.00	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	0	0	0	0	0	0	15.00
16.00	0	0	0	0	0	0	16.00
17.00	0	0	0	0	0	0	17.00
18.00	0	0	0	0	0	0	18.00
19.00	0	0	0	0	0	0	19.00
20.00	0	0	0	0	0	0	20.00
21.00	0	0	0	0	0	0	21.00
22.00	0	0	0	0	0	0	22.00
23.00	0	0	0	0	0	0	23.00
23.50	0	0	0	0	0	0	23.50
24.00	690,391	33,535	30,675	29,275	71,400	855,276	24.00
	Reclassified	Reclassified	Adjustments	Net Expenses			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00	0	0	0	0			1.00
2.00	0	0	0	0			2.00
3.00	0	0	0	0			3.00
4.00	0	0	0	0			4.00
5.00	6,436	347,953	0	347,953			5.00
HHA REIMBURSABLE SERVICES							
6.00	0	275,692	0	275,692			6.00
7.00	0	13,163	0	13,163			7.00
8.00	0	2,119	0	2,119			8.00
9.00	0	363	0	363			9.00
10.00	0	187,155	0	187,155			10.00
11.00	0	17,435	0	17,435			11.00
12.00	-4,744	13,088	0	13,088			12.00
13.00	0	0	0	0			13.00
14.00	0	0	0	0			14.00
HHA NONREIMBURSABLE SERVICES							
15.00	0	0	0	0			15.00
16.00	0	0	0	0			16.00
17.00	0	0	0	0			17.00
18.00	0	0	0	0			18.00
19.00	0	0	0	0			19.00
20.00	0	0	0	0			20.00
21.00	0	0	0	0			21.00
22.00	0	0	0	0			22.00
23.00	0	0	0	0			23.00
23.50	0	0	0	0			23.50
24.00	1,692	856,968	0	856,968			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: 14-0012	Period: From 01/01/2018 To 12/31/2018	Worksheet H-1 Part I Date/Time Prepared: 5/30/2019 2:58 pm
		HHA CCN: 14-7131	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					3.00
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	347,953	0	0	0	347,953	5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	275,692	0	0	0	275,692	6.00	
7.00	Physical Therapy	13,163	0	0	0	13,163	7.00	
8.00	Occupational Therapy	2,119	0	0	0	2,119	8.00	
9.00	Speech Pathology	363	0	0	0	363	9.00	
10.00	Medical Social Services	187,155	0	0	0	187,155	10.00	
11.00	Home Health Aide	17,435	0	0	0	17,435	11.00	
12.00	Supplies (see instructions)	13,088	0	0	0	13,088	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)	856,968	0	0	0	856,968	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	347,953					5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	188,457	464,149				6.00
7.00	Physical Therapy	8,998	22,161				7.00
8.00	Occupational Therapy	1,449	3,568				8.00
9.00	Speech Pathology	248	611				9.00
10.00	Medical Social Services	127,936	315,091				10.00
11.00	Home Health Aide	11,918	29,353				11.00
12.00	Supplies (see instructions)	8,947	22,035				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)		856,968				24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-0012

Period: From 01/01/2018

Worksheet H-1

HHA CCN: 14-7131

To 12/31/2018

Part II
Date/Time Prepared:
5/30/2019 2:58 pm

Home Health
Agency I

PPS

	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	100		4.00
5.00	Administrative and General	0	0	0	100	-347,953	509,015
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	275,692
7.00	Physical Therapy	0	0	0	0	0	13,163
8.00	Occupational Therapy	0	0	0	0	0	2,119
9.00	Speech Pathology	0	0	0	0	0	363
10.00	Medical Social Services	0	0	0	0	0	187,155
11.00	Home Health Aide	0	0	0	0	0	17,435
12.00	Supplies (see instructions)	0	0	0	0	0	13,088
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	100	-347,953	509,015
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		347,953
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.683581

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS		Provider CCN: 14-0012	Period: From 01/01/2018 To 12/31/2018	Worksheet H-2 Part I Date/Time Prepared: 5/30/2019 2:58 pm
		HHA CCN: 14-7131	Home Health Agency I	PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	DATA PROCESSING	
		BLDG & FIXT	MVBLE EQUIP				
		1.00	2.00				
1.00 Administrative and General	0	22,809	854	72,402	6,714	45,398	1.00
2.00 Skilled Nursing Care	464,149	13,183	0	73,771	4,795	28,374	2.00
3.00 Physical Therapy	22,161	0	0	0	0	0	3.00
4.00 Occupational Therapy	3,568	0	0	0	0	0	4.00
5.00 Speech Pathology	611	0	0	0	0	0	5.00
6.00 Medical Social Services	315,091	0	0	52,380	0	0	6.00
7.00 Home Health Aide	29,353	1,903	0	4,072	959	5,675	7.00
8.00 Supplies (see instructions)	22,035	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)	856,968	37,895	854	202,625	12,468	79,447	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	PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
	5.03	5.04	5A.04	5.05	7.00	8.00	
1.00 Administrative and General	2,301	17,386	167,864	18,777	48,005	0	1.00
2.00 Skilled Nursing Care	0	0	584,272	65,356	27,745	0	2.00
3.00 Physical Therapy	0	0	22,161	2,479	0	0	3.00
4.00 Occupational Therapy	0	0	3,568	399	0	0	4.00
5.00 Speech Pathology	0	0	611	68	0	0	5.00
6.00 Medical Social Services	0	0	367,471	41,105	0	0	6.00
7.00 Home Health Aide	0	0	41,962	4,694	4,004	0	7.00
8.00 Supplies (see instructions)	0	0	22,035	2,465	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)	2,301	17,386	1,209,944	135,343	79,754	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.			0.000000				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: 14-0012

Period: From 01/01/2018

Worksheet H-2

HHA CCN: 14-7131

To 12/31/2018

Part I
Date/Time Prepared:
5/30/2019 2:58 pm

Home Health Agency I

PPS

Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	9,749	0	26,858	82,067	0	33	1.00
2.00	Skilled Nursing Care	5,688	0	15,348	0	0	18	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	813	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	3	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)	16,250	0	42,206	82,067	0	54	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		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	UTILIZATION REVIEW	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES A	SERVICES-OTHER PRGM COSTS A	Subtotal	
		16.00	17.00	17.01	21.00	22.00	24.00	
1.00	Administrative and General	0	0	0	0	0	353,353	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	698,427	2.00
3.00	Physical Therapy	0	0	0	0	0	24,640	3.00
4.00	Occupational Therapy	0	0	0	0	0	3,967	4.00
5.00	Speech Pathology	0	0	0	0	0	679	5.00
6.00	Medical Social Services	0	0	0	0	0	408,576	6.00
7.00	Home Health Aide	0	0	0	0	0	51,473	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	24,503	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	1,565,618	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: 14-0012	Period: From 01/01/2018	Worksheet H-2 Part I
		HHA CCN: 14-7131	To 12/31/2018	Date/Time Prepared: 5/30/2019 2:58 pm
			Home Health Agency I	PPS

Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs		
	25.00	26.00	27.00	28.00		
1.00 Administrative and General	0	353,353				1.00
2.00 Skilled Nursing Care	0	698,427	203,579	902,006		2.00
3.00 Physical Therapy	0	24,640	7,182	31,822		3.00
4.00 Occupational Therapy	0	3,967	1,156	5,123		4.00
5.00 Speech Pathology	0	679	198	877		5.00
6.00 Medical Social Services	0	408,576	119,093	527,669		6.00
7.00 Home Health Aide	0	51,473	15,003	66,476		7.00
8.00 Supplies (see instructions)	0	24,503	7,142	31,645		8.00
9.00 Drugs	0	0	0	0		9.00
10.00 DME	0	0	0	0		10.00
11.00 Home Dialysis Aide Services	0	0	0	0		11.00
12.00 Respiratory Therapy	0	0	0	0		12.00
13.00 Private Duty Nursing	0	0	0	0		13.00
14.00 Clinic	0	0	0	0		14.00
15.00 Health Promotion Activities	0	0	0	0		15.00
16.00 Day Care Program	0	0	0	0		16.00
17.00 Home Delivered Meals Program	0	0	0	0		17.00
18.00 Homemaker Service	0	0	0	0		18.00
19.00 All Others (specify)	0	0	0	0		19.00
19.50 Telemedicine	0	0	0	0		19.50
20.00 Total (sum of lines 1-19) (2)	0	1,565,618	353,353	1,565,618		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.			0.291482			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: 14-0012 HHA CCN: 14-7131	Period: From 01/01/2018 To 12/31/2018	Worksheet H-2 Part II Date/Time Prepared: 5/30/2019 2:58 pm
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		Home Health Agency I	PPS
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (TELEPHONES)	DATA PROCESSING (NUMBER OF MACHINES)	PURCHASING RECEIVING AND STORES (COST OF SUPPLIES)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00					
1.00 Administrative and General	2,206	823	246,691	7	8	19,845	1.00
2.00 Skilled Nursing Care	1,275	0	251,355	5	5	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	178,470	0	0	0	6.00
7.00 Home Health Aide	184	0	13,875	1	1	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)	3,665	823	690,391	13	14	19,845	20.00
21.00 Total cost to be allocated	37,895	854	202,625	12,468	79,447	2,301	21.00
22.00 Unit cost multiplier	10.339700	1.037667	0.293493	959.076923	5,674.785714	0.115949	22.00
Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMIN & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
	5.04	5A.05	5.05	7.00	8.00	9.00	
1.00 Administrative and General	1,239,902	0	167,864	2,206	0	12	1.00
2.00 Skilled Nursing Care	0	0	584,272	1,275	0	7	2.00
3.00 Physical Therapy	0	0	22,161	0	0	0	3.00
4.00 Occupational Therapy	0	0	3,568	0	0	0	4.00
5.00 Speech Pathology	0	0	611	0	0	0	5.00
6.00 Medical Social Services	0	0	367,471	0	0	0	6.00
7.00 Home Health Aide	0	0	41,962	184	0	1	7.00
8.00 Supplies (see instructions)	0	0	22,035	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)	1,239,902		1,209,944	3,665	0	20	20.00
21.00 Total cost to be allocated	17,386		135,343	79,754	0	16,250	21.00
22.00 Unit cost multiplier	0.014022		0.111859	21.760982	0.000000	812.500000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 14-0012 HHA CCN: 14-7131	Period: From 01/01/2018 To 12/31/2018	Worksheet H-2 Part II Date/Time Prepared: 5/30/2019 2:58 pm
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Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIREMENTS)	PHARMACY (COSTED REQUIREMENTS)	MEDICAL RECORDS & LIBRARY (I/P GROSS CHARGES)	
	10.00	11.00	13.00	14.00	15.00	16.00	
1.00 Administrative and General	0	7	23,699	0	48	0	1.00
2.00 Skilled Nursing Care	0	4	0	0	27	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	4	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	0	11	23,699	0	79	0	20.00
21.00 Total cost to be allocated	0	42,206	82,067	0	54	0	21.00
22.00 Unit cost multiplier	0.000000	3,836.909091	3.462889	0.000000	0.683544	0.000000	22.00

Cost Center Description	INTERNS & RESIDENTS					
	SOCIAL SERVICE (PATIENT DAYS)	UTILIZATION REVIEW (PATIENT DAYS)	SERVICES-SALARY & FRINGES (PATIENT DAYS)	SERVICES-OTHER PRGM COSTS (PATIENT DAYS)		
	17.00	17.01	21.00	22.00		
1.00 Administrative and General	0	0	0	0		1.00
2.00 Skilled Nursing Care	0	0	0	0		2.00
3.00 Physical Therapy	0	0	0	0		3.00
4.00 Occupational Therapy	0	0	0	0		4.00
5.00 Speech Pathology	0	0	0	0		5.00
6.00 Medical Social Services	0	0	0	0		6.00
7.00 Home Health Aide	0	0	0	0		7.00
8.00 Supplies (see instructions)	0	0	0	0		8.00
9.00 Drugs	0	0	0	0		9.00
10.00 DME	0	0	0	0		10.00
11.00 Home Dialysis Aide Services	0	0	0	0		11.00
12.00 Respiratory Therapy	0	0	0	0		12.00
13.00 Private Duty Nursing	0	0	0	0		13.00
14.00 Clinic	0	0	0	0		14.00
15.00 Health Promotion Activities	0	0	0	0		15.00
16.00 Day Care Program	0	0	0	0		16.00
17.00 Home Delivered Meals Program	0	0	0	0		17.00
18.00 Homemaker Service	0	0	0	0		18.00
19.00 All Others (specify)	0	0	0	0		19.00
19.50 Telemedicine	0	0	0	0		19.50
20.00 Total (sum of lines 1-19)	0	0	0	0		20.00
21.00 Total cost to be allocated	0	0	0	0		21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.000000	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 14-0012	Period: From 01/01/2018 To 12/31/2018	Worksheet H-3 Part I Date/Time Prepared: 5/30/2019 2:58 pm
		HHA CCN: 14-7131	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 (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	902,006		902,006	2,307	390.99	1.00
2.00	Physical Therapy	3.00	31,822	273,943	305,765	2,504	122.11	2.00
3.00	Occupational Therapy	4.00	5,123	60,990	66,113	403	164.05	3.00
4.00	Speech Pathology	5.00	877	11,482	12,359	69	179.12	4.00
5.00	Medical Social Services	6.00	527,669		527,669	3	175,889.67	5.00
6.00	Home Health Aide	7.00	66,476		66,476	549	121.09	6.00
7.00	Total (sum of lines 1-6)		1,533,973	346,415	1,880,388	5,835		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		99914	0	366		8.00
9.00	Physical Therapy		99914	0	394		9.00
10.00	Occupational Therapy		99914	0	52		10.00
11.00	Speech Pathology		99914	0	11		11.00
12.00	Medical Social Services		99914	0	1		12.00
13.00	Home Health Aide		99914	0	103		13.00
14.00	Total (sum of lines 8-13)			0	927		14.00

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

Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	31,645	0	31,645	16,055	1.971037	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	
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		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	366		0	143,102	1.00
2.00	Physical Therapy	0	394		0	48,111	2.00
3.00	Occupational Therapy	0	52		0	8,531	3.00
4.00	Speech Pathology	0	11		0	1,970	4.00
5.00	Medical Social Services	0	1		0	175,890	5.00
6.00	Home Health Aide	0	103		0	12,472	6.00
7.00	Total (sum of lines 1-6)	0	927		0	390,076	7.00

Cost Center Description	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: 14-0012 HHA CCN: 14-7131	Period: From 01/01/2018 To 12/31/2018	Worksheet H-3 Part I Date/Time Prepared: 5/30/2019 2:58 pm
				Title XVIII	Home Health Agency I	PPS
Cost Center Description	Program Covered Charges			Cost of Services		
	Part A	Part B				
		Not Subject to Deductibles & Co Insurance	Subject to Deductibles & Co Insurance	Part A	Not Subject to Deductibles & Co Insurance	Subject to Deductibles & Co Insurance
	6.00	7.00	8.00	9.00	10.00	11.00
Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies	0	16,055	0	31,645	0
16.00	Cost of Drugs		0	0	0	0
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	143,102				
2.00	Physical Therapy	48,111				
3.00	Occupational Therapy	8,531				
4.00	Speech Pathology	1,970				
5.00	Medical Social Services	175,890				
6.00	Home Health Aide	12,472				
7.00	Total (sum of lines 1-6)	390,076				
Cost Center Description						
		12.00				
Limitation Cost Computation						
8.00	Skilled Nursing Care					
9.00	Physical Therapy					
10.00	Occupational Therapy					
11.00	Speech Pathology					
12.00	Medical Social Services					
13.00	Home Health Aide					
14.00	Total (sum of lines 8-13)					

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0012
HHA CCN: 14-7131

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

Worksheet H-3
Part II
Date/Time Prepared:
5/30/2019 2:58 pm

Title XVIII

Home Health
Agency I

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	0.265652	1,031,210	273,943	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.336952	181,006	60,990	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.492071	23,334	11,482	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.083251	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.096738	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0012 HHA CCN: 14-7131	Period: From 01/01/2018 To 12/31/2018	Worksheet H-4 Part I-II Date/Time Prepared: 5/30/2019 2:58 pm
		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	168,130
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	1,509
13.00	Total PPS Reimbursement - LUPA Episodes		0	4,727
14.00	Total PPS Reimbursement - PEP Episodes		0	0
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	475
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
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	174,841
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	174,841
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	174,841
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	174,841
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	174,841
31.01	Sequestration adjustment (see instructions)		0	3,497
31.02	Demonstration payment adjustment amount after sequestration		0	0
32.00	Interim payments (see instructions)		0	171,344
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	0
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: 14-0012

HHA CCN: 14-7131

Period:

From 01/01/2018
To 12/31/2018

Worksheet H-5

Date/Time Prepared:
5/30/2019 2:58 pm

Home Health Agency I

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		171,344	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		171,344	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		171,344	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: 14-0012	Period: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III Date/Time Prepared: 5/30/2019 2:58 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		711,103	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		4,016	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)		21.64	3.00
4.00	Number of interns & residents (see instructions)		6.90	4.00
5.00	Indirect medical education percentage (see instructions)		9.42	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)		66,986	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		782,105	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