

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: 14-0032	Period: From 07/01/2017 To 06/30/2018	Worksheet S Parts I-III Date/Time Prepared: 11/27/2018 9:03 am
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PART I - COST REPORT STATUS

Provider use only

1. Electronically filed cost report
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for Full or "L" for Low.

Contractor use only

5. Cost Report Status
 (1) As Submitted
 (2) Settled without Audit
 (3) Settled with Audit
 (4) Reopened
 (5) Amended

6. Date Received:
7. Contractor No.

8. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN

10. NPR Date:
11. Contractor's Vendor Code: 4
 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 11/27/2018 Time: 9:03 am

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. ANTHONYS MEMORIAL HOSPITAL (14-0032) for the cost reporting period beginning 07/01/2017 and ending 06/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

Title

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-62,948	-91,189	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00 Total	0	-62,948	-91,189	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0032		Period: From 07/01/2017 To 06/30/2018		Worksheet S-2 Part I Date/Time Prepared: 11/26/2018 3:39 pm				
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 503 N MAPLE	PO Box:								1.00
2.00	City: EFFINGHAM	State: IL		Zip Code: 62401		County: EFFINGHAM				2.00
		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	V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	ST. ANTHONYS MEMORIAL HOSPITAL	140032	99914	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	ST. ANTHONYS MEMORIAL HOSPITAL HHA	147661	99914		02/17/1997	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	ST. ANTHONY MEMORIAL HOSPITAL HOSPI C	141658	99914		10/14/2014				14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FOHC									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)					07/01/2017	06/30/2018			20.00
21.00	Type of Control (see instructions)					1				21.00
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N			22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						2			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.	1,662	511	0	0	285	75			24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0				25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0032	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/26/2018 3:39 pm		
		Urban/Rural	S	Date of Geogr		
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.		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.		0			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.		N			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) or (ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)		N		N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)		N		N	40.00
		V	XVII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)		N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.		N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.		N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.		N	N	N	48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.		N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.		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
		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
61.01	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

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	Y/N	IME	Direct GME	IME	Direct GME			
	1.00	2.00	3.00	4.00	5.00			
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04	
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05	
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06	
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
	1.00		2.00	3.00	4.00			
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						61.10	0.00 0.00
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.						61.20	0.00 0.00
							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)						62.00	0.00
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)						62.01	0.00
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)						63.00	N
	Program Name		Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
	1.00		2.00	3.00	4.00	5.00		
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)						64.00	0.00 0.00 0.000000

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

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			1.00	2.00	3.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?		N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00

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		Physical	Occupational	Speech	Respiratory			
		1.00	2.00	3.00	4.00			
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N			109.00
					1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N			110.00
					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.				Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.				N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.				0			118.00
		Premiums		Losses		Insurance		
		1.00		2.00		3.00		
118.01	List amounts of malpractice premiums and paid losses:	143,322		124,981		1,084,955		118.01
						1.00		
						2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.				N			118.02
119.00	DO NOT USE THIS LINE							119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.				N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.				Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.				N			122.00
Transplant Center Information								
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.				N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.							134.00
All Providers								

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0032		Period: From 07/01/2017 To 06/30/2018		Worksheet S-2 Part I Date/Time Prepared: 11/26/2018 3:39 pm	
		1.00	2.00				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y				140.00	
		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: HOSPITAL SISTERS HEALTH SYSTEM	Contractor's Name: NGS		Contractor's Number: 00131		141.00	
142.00	Street: 4936 LAVERNA ROAD	PO Box:				142.00	
143.00	City: SPRINGFIELD	State: IL		Zip Code: 62707		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y					144.00
						1.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y					145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N					146.00
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N					147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N					148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N					149.00
						1.00	
		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	
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N					165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y					167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)						168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99					169.00
						1.00	
						1.00	
						1.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2017	06/30/2018			170.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0032	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/26/2018 3:39 pm
		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. 1, 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		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0032		Period: From 07/01/2017 To 06/30/2018		Worksheet S-2 Part II Date/Time Prepared: 11/26/2018 3:39 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)	Y					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	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.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					1.00
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	11/08/2018	Y	11/08/2018		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: 14-0032	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/26/2018 3:39 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.	FRED		HELFRICH	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-231-5544		211 N BROADWAY STE 600, ST LOUIS, MO	43.00

		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.	PARTNER	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: 14-0032

Period:
From 07/01/2017
To 06/30/2018

Worksheet S-3
Part I
Date/Time Prepared:
11/26/2018 3:39 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps	
					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	123	44,895	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)		123	44,895	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	10	3,650	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)		133	48,545	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			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)		133				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: 14-0032

Period:
From 07/01/2017
To 06/30/2018

Worksheet S-3
Part I
Date/Time Prepared:
11/26/2018 3:39 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	7,966	1,260	13,073			1.00
2.00 HMO and other (see instructions)	172	567				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	7,966	1,260	13,073			7.00
8.00 INTENSIVE CARE UNIT	1,105	118	1,716			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		513	1,410			13.00
14.00 Total (see instructions)	9,071	1,891	16,199	0.00	892.03	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	46,497	6,495	68,859	0.00	123.15	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0	0	0	0.00	28.56	24.00
24.10 HOSPICE (non-distinct part)	0	0	60			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	1,043.74	27.00
28.00 Observation Bed Days		187	1,646			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			247			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	75	148			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: 14-0032

Period:
From 07/01/2017
To 06/30/2018

Worksheet S-3
Part I
Date/Time Prepared:
11/26/2018 3:39 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	2,398	607	4,776	1.00
2.00 HMO and other (see instructions)				43	0		2.00
3.00 HMO IPF Subprovider					0		3.00
4.00 HMO IRF Subprovider					0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0		2,398	607	4,776	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY	0.00						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE	0.00						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: 14-0032

Period:
From 07/01/2017
To 06/30/2018

Worksheet S-3
Part II
Date/Time Prepared:
11/26/2018 3:39 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	43,893,210	0	43,893,210	2,170,957.83	20.22 1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00 2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00 3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00 4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00 4.01
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00 5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00 6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00 7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00 7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00 8.00
9.00	SNF	44.00	0	0	0	0.00	0.00 9.00
10.00	Excluded area salaries (see instructions)		7,747,984	0	7,747,984	317,621.32	24.39 10.00
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		1,353,881	0	1,353,881	20,203.32	67.01 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		45,353	0	45,353	351.50	129.03 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		4,125,230	0	4,125,230	80,257.67	51.40 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)		15,198,575	0	15,198,575		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		2,895,716	0	2,895,716		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		1,903,532	0	1,903,532		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0032

Period:
From 07/01/2017
To 06/30/2018

Worksheet S-3
Part II
Date/Time Prepared:
11/26/2018 3:39 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	
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	430,602	0	430,602	110.25	3,905.69	26.00
27.00	Administrative & General	5.00	4,586,567	0	4,586,567	151,117.22	30.35	27.00
28.00	Administrative & General under contract (see inst.)		56,378	0	56,378	221.25	254.82	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	875,308	0	875,308	69,940.68	12.52	30.00
31.00	Laundry & Linen Service	8.00	48,967	0	48,967	3,580.75	13.68	31.00
32.00	Housekeeping	9.00	643,493	0	643,493	90,952.44	7.08	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	797,736	-499,037	298,699	22,630.82	13.20	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	499,037	499,037	53,706.00	9.29	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,122,177	0	1,122,177	39,171.75	28.65	38.00
39.00	Central Services and Supply	14.00	8,860	0	8,860	579.50	15.29	39.00
40.00	Pharmacy	15.00	1,285,294	0	1,285,294	41,823.69	30.73	40.00
41.00	Medical Records & Medical Records Library	16.00	2,401,145	0	2,401,145	34,982.28	68.64	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0032

Period:
From 07/01/2017
To 06/30/2018

Worksheet S-3
Part III
Date/Time Prepared:
11/26/2018 3:39 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Sal ari es (from Worksheet A-6)	Adjusted Sal ari es (col . 2 ± col . 3)	Pai d Hours Related to Sal ari es i n 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)	43,949,588	0	43,949,588	2,171,179.08	20.24	1.00
2.00	Excluded area salaries (see instructions)	7,747,984	0	7,747,984	317,621.32	24.39	2.00
3.00	Subtotal salaries (line 1 minus line 2)	36,201,604	0	36,201,604	1,853,557.76	19.53	3.00
4.00	Subtotal other wages & related costs (see inst.)	5,524,464	0	5,524,464	100,812.49	54.80	4.00
5.00	Subtotal wage-related costs (see inst.)	17,102,107	0	17,102,107	0.00	47.24	5.00
6.00	Total (sum of lines 3 thru 5)	58,828,175	0	58,828,175	1,954,370.25	30.10	6.00
7.00	Total overhead cost (see instructions)	12,256,527	0	12,256,527	508,816.63	24.09	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 14-0032	Period: From 07/01/2017 To 06/30/2018	Worksheet S-3 Part IV Date/Time Prepared: 11/26/2018 3:39 pm
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	263,539	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)	5,043,023	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	8,998,416	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	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)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	768,469	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	0	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	40,482	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	84,062	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	15,197,991	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: 14-0032	Period: From 07/01/2017 To 06/30/2018	Worksheet S-3 Part V Date/Time Prepared: 11/26/2018 3:39 pm
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	1,353,881	15,197,991	1.00
2.00	Hospital	1,353,881	15,197,991	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 14-0032 Component CCN: 14-7661			Period: From 07/01/2017 To 06/30/2018		Worksheet S-4 Date/Time Prepared: 11/26/2018 3:39 pm	
					Home Health Agency I		PPS	
					1.00			
0.00	County						0.00	
		Title V	Title XVIII	Title XIX	Other	Total		
		1.00	2.00	3.00	4.00	5.00		
HOME HEALTH AGENCY STATISTICAL DATA								
1.00	Home Health Aide Hours	0	9,488	0	13,159	22,647	1.00	
2.00	Unduplicated Census Count (see instructions)	0.00	1,440.00	0.00	0.00	0.00	2.00	
					Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week			Staff	Contract	Total	
		0			1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES								
3.00	Administrator and Assistant Administrator(s)	40.00			0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)				0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel				13.97	0.00	13.97	5.00
6.00	Direct Nursing Service				77.29	0.00	77.29	6.00
7.00	Nursing Supervisor				0.00	0.00	0.00	7.00
8.00	Physical Therapy Service				16.90	0.00	16.90	8.00
9.00	Physical Therapy Supervisor				0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service				4.88	0.00	4.88	10.00
11.00	Occupational Therapy Supervisor				0.00	0.00	0.00	11.00
12.00	Speech Pathology Service				1.36	0.00	1.36	12.00
13.00	Speech Pathology Supervisor				0.00	0.00	0.00	13.00
14.00	Medical Social Service				2.43	0.00	2.43	14.00
15.00	Medical Social Service Supervisor				0.00	0.00	0.00	15.00
16.00	Home Health Aide				6.33	0.00	6.33	16.00
17.00	Home Health Aide Supervisor				0.00	0.00	0.00	17.00
18.00	Other (specify)				0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES								
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.				4			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).				41180			20.00
20.01					99914			20.01
20.02					16060			20.02
20.03					44180			20.03
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)		
		Without Outliers	With Outliers					
		1.00	2.00	3.00	4.00	5.00		
PPS ACTIVITY DATA								
21.00	Skilled Nursing Visits	13,008	5,147	420	449	19,024	21.00	
22.00	Skilled Nursing Visit Charges	2,821,651	1,116,899	90,923	97,433	4,126,906	22.00	
23.00	Physical Therapy Visits	6,908	1,137	89	239	8,373	23.00	
24.00	Physical Therapy Visit Charges	1,595,748	262,647	20,559	55,209	1,934,163	24.00	
25.00	Occupational Therapy Visits	1,927	377	16	70	2,390	25.00	
26.00	Occupational Therapy Visit Charges	445,137	87,087	3,696	16,170	552,090	26.00	
27.00	Speech Pathology Visits	428	92	8	3	531	27.00	
28.00	Speech Pathology Visit Charges	98,868	21,252	1,848	693	122,661	28.00	
29.00	Medical Social Service Visits	162	39	2	4	207	29.00	
30.00	Medical Social Service Visit Charges	46,117	11,154	572	1,144	58,987	30.00	
31.00	Home Health Aide Visits	1,913	1,263	4	27	3,207	31.00	
32.00	Home Health Aide Visit Charges	200,865	132,615	420	2,835	336,735	32.00	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	24,346	8,055	539	792	33,732	33.00	
34.00	Other Charges	0	0	0	0	0	34.00	
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	5,208,386	1,631,654	118,018	173,484	7,131,542	35.00	
36.00	Total Number of Episodes (standard/non outlier)	1,631		189	55	1,875	36.00	
37.00	Total Number of Outlier Episodes		225		13	238	37.00	
38.00	Total Non-Routine Medical Supply Charges	125,937	113,304	3,371	5,739	248,351	38.00	

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA		Provider CCN: 14-0032 Hospice CCN: 14-1658	Period: From 07/01/2017 To 06/30/2018	Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 11/26/2018 3:39 pm
		Hospice I		

	Unduplicated Days	Hospice I				Total (sum of cols. 1, 2 & 5)		
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility			All Other
		1.00	2.00	3.00	4.00			5.00
PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015								
1.00	Hospice Continuous Home Care						1.00	
2.00	Hospice Routine Home Care						2.00	
3.00	Hospice Inpatient Respite Care						3.00	
4.00	Hospice General Inpatient Care						4.00	
5.00	Total Hospice Days						5.00	
Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015								
6.00	Number of patients receiving hospice care						6.00	
7.00	Total number of unduplicated Continuous Care hours billable to Medicare						7.00	
8.00	Average Length of Stay (line 5 / line 6)						8.00	
9.00	Unduplicated census count						9.00	

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	14,203	858	871	15,932	11.00
12.00	Hospice Inpatient Respite Care	29	0	0	29	12.00
13.00	Hospice General Inpatient Care	236	8	9	253	13.00
14.00	Total Hospice Days	14,468	866	880	16,214	14.00
PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
15.00	Hospice Inpatient Respite Care	29	0	0	29	15.00
16.00	Hospice General Inpatient Care	236	8	9	253	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0032	Period: From 07/01/2017 To 06/30/2018	Worksheet S-10 Date/Time Prepared: 11/26/2018 3:39 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)		0.309626		1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid		5,949,996		2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y		3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y		4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0		5.00	
6.00	Medicaid charges		55,381,474		6.00	
7.00	Medicaid cost (line 1 times line 6)		17,147,544		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)		11,197,548		8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)						
9.00	Net revenue from stand-alone CHIP		0		9.00	
10.00	Stand-alone CHIP charges		0		10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)		0		11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0		12.00	
Other state or local government indigent care program (see instructions for each line)						
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0		13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0		14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0		15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0		16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)						
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0		18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		11,197,548		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)	2,999,473	7,143,817	10,143,290	20.00	
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	928,715	7,143,817	8,072,532	21.00	
22.00	Payments received from patients for amounts previously written off as charity care	47,858	103,372	151,230	22.00	
23.00	Cost of charity care (line 21 minus line 22)	880,857	7,040,445	7,921,302	23.00	
				1.00		
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00	
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0		25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		995,786		26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		186,007		27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		286,164		27.01	
28.00	Non-Medicare bad debt expense (see instructions)		709,622		28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		319,874		29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		8,241,176		30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		19,438,724		31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0032

Period:
From 07/01/2017
To 06/30/2018

Worksheet A
Date/Time Prepared:
11/26/2018 3:39 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		4,024,799	4,024,799	-1,589,829	2,434,970	1.00
2.00	00200		0	0	1,995,489	1,995,489	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	430,602	9,680,040	10,110,642	-32,455	10,078,187	4.00
5.00	00500	4,586,567	27,396,187	31,982,754	0	31,982,754	5.00
6.00	00600	0	9,763	9,763	0	9,763	6.00
7.00	00700	875,308	1,960,217	2,835,525	-89,645	2,745,880	7.00
8.00	00800	48,967	452,274	501,241	-211	501,030	8.00
9.00	00900	643,493	262,691	906,184	-12,106	894,078	9.00
10.00	01000	797,736	604,398	1,402,134	-958,852	443,282	10.00
11.00	01100	0	0	0	953,738	953,738	11.00
13.00	01300	1,122,177	44,449	1,166,626	-2,901	1,163,725	13.00
14.00	01400	8,860	1,335,720	1,344,580	-1,306,983	37,597	14.00
15.00	01500	1,285,294	4,572,282	5,857,576	-4,191,353	1,666,223	15.00
16.00	01600	2,401,145	1,427,475	3,828,620	-334	3,828,286	16.00
17.00	01700	0	90	90	0	90	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	6,055,684	859,955	6,915,639	-1,678,807	5,236,832	30.00
31.00	03100	1,329,089	59,673	1,388,762	-32,876	1,355,886	31.00
43.00	04300	0	19,894	19,894	384,574	404,468	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	4,159,042	9,610,783	13,769,825	-8,275,967	5,493,858	50.00
52.00	05200	0	57,722	57,722	1,049,536	1,107,258	52.00
53.00	05300	2,225,073	2,669,720	4,894,793	-161,439	4,733,354	53.00
54.00	05400	1,698,278	982,031	2,680,309	-181,501	2,498,808	54.00
54.01	03630	171,671	105,565	277,236	-37,170	240,066	54.01
54.02	03450	174,057	320,105	494,162	-17,021	477,141	54.02
54.06	05404	0	128,325	128,325	0	128,325	54.06
57.00	05700	320,329	350,196	670,525	-6,163	664,362	57.00
58.00	05800	219,066	263,079	482,145	-10,635	471,510	58.00
59.00	05900	393,067	791,111	1,184,178	-692,229	491,949	59.00
60.00	06000	1,330,210	2,256,638	3,586,848	-1,223,208	2,363,640	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	509,407	128,044	637,451	-36,868	600,583	65.00
66.00	06600	1,460,062	384,807	1,844,869	-11,779	1,833,090	66.00
67.00	06700	409,879	27,799	437,678	-18,956	418,722	67.00
69.00	06900	571,364	275,699	847,063	-19,292	827,771	69.00
70.00	07000	162,171	35,036	197,207	-24,435	172,772	70.00
71.00	07100	0	0	0	8,471,920	8,471,920	71.00
72.00	07200	0	0	0	4,443,832	4,443,832	72.00
73.00	07300	0	0	0	4,452,368	4,452,368	73.00
74.00	07400	0	40,972	40,972	-2,545	38,427	74.00
76.00	03050	0	0	0	0	0	76.00
76.01	03650	210,521	33,747	244,268	-2,910	241,358	76.01
76.03	03950	453,998	852,577	1,306,575	-93,998	1,212,577	76.03
76.97	07697	92,025	1,991	94,016	-1,294	92,722	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	152,117	5,743	157,860	-5,412	152,448	90.00
91.00	09100	1,847,967	2,305,790	4,153,757	-115,639	4,038,118	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	6,484,449	1,548,758	8,033,207	-352,807	7,680,400	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		318,182	318,182	-318,182	0	113.00
116.00	11600	1,169,621	1,069,155	2,238,776	-245,547	1,993,229	116.00
118.00		43,799,296	77,273,482	121,072,778	108	121,072,886	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	21,408	21,408	0	21,408	190.00
194.00	07950	93,914	3,609,021	3,702,935	-108	3,702,827	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
200.00		43,893,210	80,903,911	124,797,121	0	124,797,121	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0032

Period:
From 07/01/2017
To 06/30/2018

Worksheet A
Date/Time Prepared:
11/26/2018 3:39 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	-109,048	2,325,922	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	781,001	2,776,490	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,226,574	14,304,761	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,443,299	29,539,455	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	9,763	6.00
7.00	00700	OPERATION OF PLANT	-22,444	2,723,436	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	501,030	8.00
9.00	00900	HOUSEKEEPING	-34	894,044	9.00
10.00	01000	DIETARY	-50,918	392,364	10.00
11.00	01100	CAFETERIA	0	953,738	11.00
13.00	01300	NURSING ADMINISTRATION	-831	1,162,894	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	37,597	14.00
15.00	01500	PHARMACY	0	1,666,223	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-187,758	3,640,528	16.00
17.00	01700	SOCIAL SERVICE	0	90	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-10,263	5,226,569	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,355,886	31.00
43.00	04300	NURSERY	0	404,468	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-250	5,493,608	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,107,258	52.00
53.00	05300	ANESTHESIOLOGY	-4,474,490	258,864	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,660	2,497,148	54.00
54.01	03630	ULTRA SOUND	-1,400	238,666	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	477,141	54.02
54.06	05404	PET SCAN	0	128,325	54.06
57.00	05700	CT SCAN	0	664,362	57.00
58.00	05800	MRI	0	471,510	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	491,949	59.00
60.00	06000	LABORATORY	-2,633	2,361,007	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	600,583	65.00
66.00	06600	PHYSICAL THERAPY	-10,000	1,823,090	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	418,722	67.00
69.00	06900	ELECTROCARDIOLOGY	-135,703	692,068	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-3,300	169,472	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	8,471,920	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	4,443,832	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-5,530	4,446,838	73.00
74.00	07400	RENAL DIALYSIS	0	38,427	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	76.00
76.01	03650	VASCULAR LAB	0	241,358	76.01
76.03	03950	WOUND CARE	-183,773	1,028,804	76.03
76.97	07697	CARDIAC REHABILITATION	0	92,722	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	152,448	90.00
91.00	09100	EMERGENCY	-1,644,013	2,394,105	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	-3,739	7,676,661	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	0	1,993,229	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,283,511	116,789,375	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	21,408	190.00
194.00	07950	PHILANTHROPY DEVELOPMENT	0	3,702,827	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-4,283,511	120,513,610	200.00

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
B - CAFETERIA COSTS						
1.00	CAFETERIA	11.00	499,037	454,701	1.00	
	0		499,037	454,701		
C - PHARMACY DRUGS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,452,368	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
21.00		0.00	0	0	21.00	
22.00		0.00	0	0	22.00	
23.00		0.00	0	0	23.00	
24.00		0.00	0	0	24.00	
	0		0	4,452,368		
D - CENTRAL SUPPLY						
1.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	8,471,920	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
21.00		0.00	0	0	21.00	
22.00		0.00	0	0	22.00	
23.00		0.00	0	0	23.00	
24.00		0.00	0	0	24.00	
25.00		0.00	0	0	25.00	
26.00		0.00	0	0	26.00	
27.00		0.00	0	0	27.00	
28.00		0.00	0	0	28.00	
29.00		0.00	0	0	29.00	
30.00		0.00	0	0	30.00	
31.00		0.00	0	0	31.00	
32.00		0.00	0	0	32.00	
33.00		0.00	0	0	33.00	
34.00		0.00	0	0	34.00	
35.00		0.00	0	0	35.00	
36.00		0.00	0	0	36.00	
	0		0	8,471,920		
E - PROPERTY INSURANCE EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	48,450	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	39,028	2.00	
	0		0	87,478		

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
F - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	318,182	1.00
	O		0	318,182	
G - DEPRECIATION EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,956,461	1.00
	O		0	1,956,461	
H - LABOR & DELIVERY					
1.00	NURSERY	43.00	393,770	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1,102,893	0	2.00
	O		1,496,663	0	
I - IMPLANT RECLASS					
1.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00	0	4,443,832	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	O		0	4,443,832	
500.00	Grand Total: Increases		1,995,700	20,184,942	500.00

RECLASSIFICATIONS

Provider CCN: 14-0032

Period:
From 07/01/2017
To 06/30/2018

Worksheet A-6
Date/Time Prepared:
11/26/2018 3:39 pm

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
B - CAFETERIA COSTS						
1.00	DIETARY	10.00	499,037	454,701	0	1.00
	O		499,037	454,701		
C - PHARMACY DRUGS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	32,387	0	1.00
2.00	DIETARY	10.00	0	6	0	2.00
3.00	NURSING ADMINISTRATION	13.00	0	233	0	3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	44,014	0	4.00
5.00	PHARMACY	15.00	0	4,013,031	0	5.00
6.00	ADULTS & PEDIATRICS	30.00	0	12,040	0	6.00
7.00	INTENSIVE CARE UNIT	31.00	0	1,977	0	7.00
8.00	OPERATING ROOM	50.00	0	21,380	0	8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	0	382	0	9.00
10.00	ANESTHESIOLOGY	53.00	0	65,689	0	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,766	0	11.00
12.00	NUCLEAR MEDICINE - DIAGNOSTIC	54.02	0	15,795	0	12.00
13.00	MRI	58.00	0	782	0	13.00
14.00	CARDIAC CATHETERIZATION	59.00	0	2,187	0	14.00
15.00	LABORATORY	60.00	0	11,965	0	15.00
16.00	RESPIRATORY THERAPY	65.00	0	203	0	16.00
17.00	PHYSICAL THERAPY	66.00	0	38	0	17.00
18.00	OCCUPATIONAL THERAPY	67.00	0	22	0	18.00
19.00	ELECTROCARDIOLOGY	69.00	0	1,039	0	19.00
20.00	WOUND CARE	76.03	0	7,628	0	20.00
21.00	CLINIC	90.00	0	35	0	21.00
22.00	EMERGENCY	91.00	0	5,444	0	22.00
23.00	HOME HEALTH AGENCY	101.00	0	5,206	0	23.00
24.00	HOSPICE	116.00	0	207,119	0	24.00
	O		0	4,452,368		
D - CENTRAL SUPPLY						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	68	0	1.00
2.00	OPERATION OF PLANT	7.00	0	2,167	0	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	211	0	3.00
4.00	HOUSEKEEPING	9.00	0	12,106	0	4.00
5.00	DIETARY	10.00	0	5,108	0	5.00
6.00	NURSING ADMINISTRATION	13.00	0	2,668	0	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,262,969	0	7.00
8.00	PHARMACY	15.00	0	178,322	0	8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	334	0	9.00
10.00	ADULTS & PEDIATRICS	30.00	0	170,104	0	10.00
11.00	INTENSIVE CARE UNIT	31.00	0	30,899	0	11.00
12.00	NURSERY	43.00	0	9,196	0	12.00
13.00	OPERATING ROOM	50.00	0	4,139,705	0	13.00
14.00	DELIVERY ROOM & LABOR ROOM	52.00	0	52,975	0	14.00
15.00	ANESTHESIOLOGY	53.00	0	95,750	0	15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	177,735	0	16.00
17.00	ULTRA SOUND	54.01	0	37,170	0	17.00
18.00	NUCLEAR MEDICINE - DIAGNOSTIC	54.02	0	1,226	0	18.00
19.00	CT SCAN	57.00	0	6,163	0	19.00
20.00	MRI	58.00	0	9,853	0	20.00
21.00	CARDIAC CATHETERIZATION	59.00	0	365,872	0	21.00
22.00	LABORATORY	60.00	0	1,211,243	0	22.00
23.00	RESPIRATORY THERAPY	65.00	0	36,665	0	23.00
24.00	PHYSICAL THERAPY	66.00	0	11,741	0	24.00
25.00	OCCUPATIONAL THERAPY	67.00	0	18,934	0	25.00
26.00	ELECTROCARDIOLOGY	69.00	0	18,253	0	26.00
27.00	ELECTROENCEPHALOGRAPHY	70.00	0	24,435	0	27.00
28.00	RENAL DIALYSIS	74.00	0	2,545	0	28.00
29.00	VASCULAR LAB	76.01	0	2,910	0	29.00
30.00	WOUND CARE	76.03	0	81,590	0	30.00
31.00	CARDIAC REHABILITATION	76.97	0	1,294	0	31.00
32.00	CLINIC	90.00	0	5,377	0	32.00
33.00	EMERGENCY	91.00	0	110,195	0	33.00
34.00	HOME HEALTH AGENCY	101.00	0	347,601	0	34.00
35.00	HOSPICE	116.00	0	38,428	0	35.00
36.00	PHILANTHROPY DEVELOPMENT	194.00	0	108	0	36.00
	O		0	8,471,920		
E - PROPERTY INSURANCE EXPENSE						
1.00	OPERATION OF PLANT	7.00	0	87,478	12	1.00
2.00		0.00	0	0	12	2.00
	O		0	87,478		

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
F - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	318,182	11	1.00
	O		0	318,182		
G - DEPRECIATION EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,956,461	9	1.00
	O		0	1,956,461		
H - LABOR & DELIVERY						
1.00	ADULTS & PEDIATRICS	30.00	1,496,663	0	0	1.00
2.00		0.00	0	0	0	2.00
	O		1,496,663	0		
I - IMPLANT RECLASS						
1.00	OPERATING ROOM	50.00	0	4,114,882	0	1.00
2.00	CARDIAC CATHETERIZATION	59.00	0	324,170	0	2.00
3.00	WOUND CARE	76.03	0	4,780	0	3.00
	O		0	4,443,832		
500.00	Grand Total: Decreases		1,995,700	20,184,942		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0032

Period:
From 07/01/2017
To 06/30/2018

Worksheet A-7
Part I
Date/Time Prepared:
11/26/2018 3:39 pm

		Acquisitions			Disposals and Retirements		
		Beginning Balances	Purchases	Donation			Total
		1.00	2.00	3.00			4.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,699,574	0	0	0	1.00	
2.00	Land Improvements	3,360,444	0	0	0	2.00	
3.00	Buildings and Fixtures	87,366,590	8,861,454	0	8,861,454	3.00	
4.00	Building Improvements	70,648	255,617	0	255,617	4.00	
5.00	Fixed Equipment	0	0	0	0	5.00	
6.00	Movable Equipment	76,823,815	4,779,231	0	4,779,231	6.00	
7.00	HIT designated Assets	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	170,321,071	13,896,302	0	13,896,302	8.00	
9.00	Reconciling Items	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	170,321,071	13,896,302	0	13,896,302	10.00	
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,699,574	0			1.00	
2.00	Land Improvements	3,360,444	2,224,783			2.00	
3.00	Buildings and Fixtures	94,598,792	31,653,301			3.00	
4.00	Building Improvements	326,265	0			4.00	
5.00	Fixed Equipment	0	14,103,995			5.00	
6.00	Movable Equipment	81,346,647	65,667,425			6.00	
7.00	HIT designated Assets	0	0			7.00	
8.00	Subtotal (sum of lines 1-7)	182,331,722	113,649,504			8.00	
9.00	Reconciling Items	0	0			9.00	
10.00	Total (line 8 minus line 9)	182,331,722	113,649,504			10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0032

Period:
From 07/01/2017
To 06/30/2018

Worksheet A-7
Part II
Date/Time Prepared:
11/26/2018 3:39 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	3,706,617	0	318,182	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)	3,706,617	0	318,182	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	4,024,799				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	4,024,799				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0032

Period:
From 07/01/2017
To 06/30/2018

Worksheet A-7
Part III
Date/Time Prepared:
11/26/2018 3:39 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	100,985,075	0	100,985,075	0.553854	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	81,346,647	0	81,346,647	0.446146	0	2.00
3.00	Total (sum of lines 1-2)	182,331,722	0	182,331,722	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,284,984	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,737,462	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,022,446	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	318,182	48,450	0	-325,694	2,325,922	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	39,028	0	0	2,776,490	2.00
3.00	Total (sum of lines 1-2)	318,182	87,478	0	-325,694	5,102,412	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0032

Period:
From 07/01/2017
To 06/30/2018

Worksheet A-8

Date/Time Prepared:
11/26/2018 3:39 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-318,182	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)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-1,030	CAP REL COSTS-MVBLE EQUIP	2.00	9	7.00
8.00 Television and radio service (chapter 21)		0		0.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-3,952,295			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	2,002,028			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests		0		0.00	0	14.00
15.00 Rental of quarters to employees 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		0		0.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines		0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant		0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		68.00	31.00			
				Basis/Code (2)	Amount			Cost Center	Line #	Wkst. A-7 Ref.
32.00	CAH HIT Adjustment for Depreciation and Interest		0			0.00	32.00			
33.00	MISC INCOME	B	-760,167	ADMINISTRATIVE & GENERAL	5.00		33.00			
33.01	MISC INCOME	B	-34	HOUSEKEEPING	9.00		33.01			
33.02	MISC INCOME	B	-50,918	DIETARY	10.00		33.02			
33.03	MISC INCOME	B	-800	NURSING ADMINISTRATION	13.00		33.03			
33.04	MISC INCOME	B	-187,758	MEDICAL RECORDS & LIBRARY	16.00		33.04			
33.05	MISC INCOME	B	-10,263	ADULTS & PEDIATRICS	30.00		33.05			
33.06	MISC INCOME	B	-250	OPERATING ROOM	50.00		33.06			
33.07	MISC INCOME	B	-2,018,549	ANESTHESIOLOGY	53.00		33.07			
33.08	MISC INCOME	B	-390	RADIOLOGY-DIAGNOSTIC	54.00		33.08			
33.09	MISC INCOME	B	-1,400	ULTRA SOUND	54.01		33.09			
33.10	MISC INCOME	B	-550	LABORATORY	60.00		33.10			
33.11	MISC INCOME	B	-5,530	DRUGS CHARGED TO PATIENTS	73.00		33.11			
33.12	MISC INCOME	B	-3,739	HOME HEALTH AGENCY	101.00		33.12			
33.13	TELEPHONE EMPLOYEE BENEFITS	A	-7,838	EMPLOYEE BENEFITS DEPARTMENT	4.00		33.13			
33.14	TELEPHONE A&G SALARIES	A	-23,623	ADMINISTRATIVE & GENERAL	5.00		33.14			
33.15	TELEPHONE A&G OTHER EXPENSE	A	-227	ADMINISTRATIVE & GENERAL	5.00		33.15			
33.16	TELEVISION EMPLOYEE BENEFITS	A	-924	EMPLOYEE BENEFITS DEPARTMENT	4.00		33.16			
33.17	TELEVISION A&G SALARIES	A	-2,785	OPERATION OF PLANT	7.00		33.17			
33.18	TELEVISION A&G OTHER EXPENSE	A	-746	OPERATION OF PLANT	7.00		33.18			
33.19	TELEVISION A&G OTHER CABLE EXPENSE	A	-18,913	OPERATION OF PLANT	7.00		33.19			
33.20	MEDICAID TAX ASSESSMENT	A	-3,695,519	ADMINISTRATIVE & GENERAL	5.00		33.20			
33.21	SELF-INS TO HOSP/EMP CLAIMS	A	-4,158,429	EMPLOYEE BENEFITS DEPARTMENT	4.00		33.21			
33.22	LOBBYING EXPENSES	A	-29,009	ADMINISTRATIVE & GENERAL	5.00		33.22			
33.23	COUNTRY CLUB FEES	A	-325	ADMINISTRATIVE & GENERAL	5.00		33.23			
33.24	ALCOHOL BEVERAGE COST	A	-1,274	ADMINISTRATIVE & GENERAL	5.00		33.24			
33.25	DEFINED PENSION ADJUSTMENT	A	8,746,844	EMPLOYEE BENEFITS DEPARTMENT	4.00		33.25			
33.26	CRNA EXPENSE	A	-473,788	ANESTHESIOLOGY	53.00		33.26			
33.27	PUBLIC RELATIONS/MARKETING	A	-42,319	ADMINISTRATIVE & GENERAL	5.00		33.27			
33.28	MISCELLANEOUS INCOME	B	-325,694	CAP REL COSTS-BLDG & FIXT	1.00	14	33.28			
33.29	BUILDING RE-LIFING	A	534,828	CAP REL COSTS-BLDG & FIXT	1.00	9	33.29			
33.30	EQUIPMENT RE-LIFING	A	782,031	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.30			
33.31	GIFTS/DONATIONS	B	-10,000	PHYSICAL THERAPY	66.00		33.31			
33.32	GIFTS/DONATIONS	B	-244,119	ADMINISTRATIVE & GENERAL	5.00		33.32			
33.33	PROPERTY TAX	B	-1,824	ADMINISTRATIVE & GENERAL	5.00		33.33			
33.34	ALCOHOL BEVERAGE COST	A	-31	NURSING ADMINISTRATION	13.00		33.34			
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,283,511				50.00			

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS
 Provider CCN: 14-0032
 Period: From 07/01/2017 To 06/30/2018
 Worksheet A-8-1
 Date/Time Prepared: 11/26/2018 3:39 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HEALTH & DENTAL PREMIUM	10,504,148	10,593,431 1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	CONTRACTED SERVICES - ISC	7,930,374	5,485,984 2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	CONTRACTED SERVICES - SSC	2,540,565	2,893,644 3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	SID- INTERCOMPANY ACTIVITY	7,038,704	7,038,704 4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			28,013,791	26,011,763 5.00

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

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

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

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

6.00	G	HSHS	100.00	HSHS	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	SISTER				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-0032	Period: From 07/01/2017 To 06/30/2018	Worksheet A-8-1 Date/Time Prepared: 11/26/2018 3:39 pm
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	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-89,283	0		1.00
2.00	2,444,390	0		2.00
3.00	-353,079	0		3.00
4.00	0	0		4.00
5.00	2,002,028			5.00

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

Related Organization(s) and/or Home Office	Type of Business		
	6.00		
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:			

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

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

6.00	CORPORATE OFFICE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT			Provider CCN: 14-0032		Period: From 07/01/2017 To 06/30/2018		Worksheet A-8-2 Date/Time Prepared: 11/26/2018 3:39 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	53.00 ANESTHESIOLOGY	1,982,153	1,982,153	0	0	0	0	1.00
2.00	54.00 RADIOLOGY-DIAGNOSTIC	15,748	1,270	14,478	271,900	0	114	2.00
3.00	60.00 LABORATORY	2,083	2,083	0	0	0	0	3.00
4.00	69.00 ELECTROCARDIOLOGY	135,703	135,703	0	0	0	0	4.00
5.00	70.00 ELECTROENCEPHALOGRAPHY	3,300	3,300	0	0	0	0	5.00
6.00	76.03 WOUND CARE	207,973	177,098	30,875	211,500	0	238	6.00
7.00	91.00 EMERGENCY	1,644,013	1,644,013	0	0	0	0	7.00
8.00	0.00	0	0	0	0	0	0	8.00
9.00	0.00	0	0	0	0	0	0	9.00
10.00	0.00	0	0	0	0	0	0	10.00
200.00		3,990,973	3,945,620	45,353			352	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	53.00 ANESTHESIOLOGY	0	0	0	0	0	0	1.00
2.00	54.00 RADIOLOGY-DIAGNOSTIC	14,902	745	0	0	0	0	2.00
3.00	60.00 LABORATORY	0	0	0	0	0	0	3.00
4.00	69.00 ELECTROCARDIOLOGY	0	0	0	0	0	0	4.00
5.00	70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	5.00
6.00	76.03 WOUND CARE	24,200	1,210	0	0	0	0	6.00
7.00	91.00 EMERGENCY	0	0	0	0	0	0	7.00
8.00	0.00	0	0	0	0	0	0	8.00
9.00	0.00	0	0	0	0	0	0	9.00
10.00	0.00	0	0	0	0	0	0	10.00
200.00		39,102	1,955	0	0	0	0	200.00
Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment			
1.00	2.00	15.00	16.00	17.00	18.00			
1.00	53.00 ANESTHESIOLOGY	0	0	0	1,982,153			1.00
2.00	54.00 RADIOLOGY-DIAGNOSTIC	0	14,902	0	1,270			2.00
3.00	60.00 LABORATORY	0	0	0	2,083			3.00
4.00	69.00 ELECTROCARDIOLOGY	0	0	0	135,703			4.00
5.00	70.00 ELECTROENCEPHALOGRAPHY	0	0	0	3,300			5.00
6.00	76.03 WOUND CARE	0	24,200	6,675	183,773			6.00
7.00	91.00 EMERGENCY	0	0	0	1,644,013			7.00
8.00	0.00	0	0	0	0			8.00
9.00	0.00	0	0	0	0			9.00
10.00	0.00	0	0	0	0			10.00
200.00		0	39,102	6,675	3,952,295			200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0032

Period:
From 07/01/2017
To 06/30/2018

Worksheet B
Part I
Date/Time Prepared:
11/26/2018 3:39 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,325,922	2,325,922			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	2,776,490		2,776,490		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	14,304,761	5,127	0	14,309,888	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	29,539,455	605,080	0	1,503,244	31,647,779
6.00 00600	MAINTENANCE & REPAIRS	9,763	0	986	0	10,749
7.00 00700	OPERATION OF PLANT	2,723,436	436,152	1,228,763	287,449	4,675,800
8.00 00800	LAUNDRY & LINEN SERVICE	501,030	11,809	1,362	16,132	530,333
9.00 00900	HOUSEKEEPING	894,044	0	2,256	211,996	1,108,296
10.00 01000	DIETARY	392,364	50,792	12,482	98,405	554,043
11.00 01100	CAFETERIA	953,738	11,657	0	164,406	1,129,801
13.00 01300	NURSING ADMINISTRATION	1,162,894	19,488	2,027	369,697	1,554,106
14.00 01400	CENTRAL SERVICES & SUPPLY	37,597	18,584	0	2,919	59,100
15.00 01500	PHARMACY	1,666,223	27,161	7,669	423,435	2,124,488
16.00 01600	MEDICAL RECORDS & LIBRARY	3,640,528	49,910	7,625	791,048	4,489,111
17.00 01700	SOCIAL SERVICE	90	0	0	0	90
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	5,226,569	300,277	122,685	1,501,951	7,151,482
31.00 03100	INTENSIVE CARE UNIT	1,355,886	31,839	56,676	437,863	1,882,264
43.00 04300	NURSERY	404,468	0	3,034	129,726	537,228
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	5,493,608	225,326	536,364	1,370,180	7,625,478
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,107,258	32,309	31,622	363,344	1,534,533
53.00 05300	ANESTHESIOLOGY	258,864	1,417	41,343	733,041	1,034,665
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,497,148	118,795	290,010	559,491	3,465,444
54.01 03630	ULTRA SOUND	238,666	3,963	42,786	56,556	341,971
54.02 03450	NUCLEAR MEDICINE - DIAGNOSTIC	477,141	17,579	819	57,342	552,881
54.06 05404	PET SCAN	128,325	0	0	0	128,325
57.00 05700	CT SCAN	664,362	10,131	1,528	105,531	781,552
58.00 05800	MRI	471,510	38,543	13,939	72,170	596,162
59.00 05900	CARDIAC CATHETERIZATION	491,949	13,392	16,287	129,494	651,122
60.00 06000	LABORATORY	2,361,007	42,390	45,256	438,232	2,886,885
62.30 06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	600,583	5,279	4,704	167,822	778,388
66.00 06600	PHYSICAL THERAPY	1,823,090	57,850	12,209	481,012	2,374,161
67.00 06700	OCCUPATIONAL THERAPY	418,722	0	0	135,033	553,755
69.00 06900	ELECTROCARDIOLOGY	692,068	29,012	70,649	188,234	979,963
70.00 07000	ELECTROENCEPHALOGRAPHY	169,472	4,939	5,071	53,427	232,909
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	8,471,920	0	0	0	8,471,920
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	4,443,832	0	0	0	4,443,832
73.00 07300	DRUGS CHARGED TO PATIENTS	4,446,838	0	0	0	4,446,838
74.00 07400	RENAL DIALYSIS	38,427	3,232	0	0	41,659
76.00 03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0
76.01 03650	VASCULAR LAB	241,358	7,108	22,625	69,355	340,446
76.03 03950	WOUND CARE	1,028,804	24,998	4,537	149,568	1,207,907
76.97 07697	CARDIAC REHABILITATION	92,722	4,773	797	30,317	128,609
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	152,448	7,022	1,758	50,114	211,342
91.00 09100	EMERGENCY	2,394,105	70,722	30,676	608,805	3,104,308
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)					0
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	7,676,661	35,448	80,474	2,136,282	9,928,865
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
116.00 11600	HOSPICE	1,993,229	0	1,653	385,327	2,380,209
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	116,789,375	2,322,104	2,700,672	14,278,948	116,678,799
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	21,408	3,818	514	0	25,740
194.00 07950	PHILANTHROPY DEVELOPMENT	3,702,827	0	75,304	30,940	3,809,071
194.01 07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.02 07952	MEALS ON WHEELS	0	0	0	0	0
194.03 07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers					0
202.00	TOTAL (sum lines 118 through 201)	120,513,610	2,325,922	2,776,490	14,309,888	120,513,610

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 14-0032	Period: From 07/01/2017 To 06/30/2018	Worksheet B Part I Date/Time Prepared: 11/26/2018 3:39 pm			
Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	31,647,779					5.00
6.00	00600	MAINTENANCE & REPAIRS	3,828	14,577				6.00
7.00	00700	OPERATION OF PLANT	1,665,193	3,743	6,344,736			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	188,867	101	58,553	777,854		8.00
9.00	00900	HOUSEKEEPING	394,697	0	0	0	1,502,993	9.00
10.00	01000	DIETARY	197,311	435	251,855	5,595	60,945	10.00
11.00	01100	CAFETERIA	402,356	99	57,800	0	14,008	11.00
13.00	01300	NURSING ADMINISTRATION	553,464	121	96,633	0	16,957	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	21,047	160	92,151	0	22,302	14.00
15.00	01500	PHARMACY	756,594	233	134,676	0	32,623	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,598,707	128	247,480	0	18,001	16.00
17.00	01700	SOCIAL SERVICE	32	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,546,857	2,572	1,488,933	235,935	360,448	30.00
31.00	03100	INTENSIVE CARE UNIT	670,331	273	157,875	33,729	38,214	31.00
43.00	04300	NURSERY	191,323	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,715,661	1,924	1,117,282	205,094	269,585	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	546,493	277	160,206	55,780	38,767	52.00
53.00	05300	ANESTHESIOLOGY	368,475	13	7,028	0	1,720	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,234,149	1,017	589,047	30,967	142,595	54.00
54.01	03630	ULTRA SOUND	121,786	34	19,649	3,863	4,731	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	196,898	151	87,167	2,645	21,073	54.02
54.06	05404	PET SCAN	45,700	0	0	0	0	54.06
57.00	05700	CT SCAN	278,334	87	50,235	9,894	12,165	57.00
58.00	05800	MRI	212,311	331	191,114	22,281	46,262	58.00
59.00	05900	CARDIAC CATHETERIZATION	231,884	114	66,406	209	16,096	59.00
60.00	06000	LABORATORY	1,028,106	363	210,190	0	50,870	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	277,207	52	26,175	6,543	7,188	65.00
66.00	06600	PHYSICAL THERAPY	845,510	496	286,850	8,425	69,424	66.00
67.00	06700	OCCUPATIONAL THERAPY	197,209	0	0	2,533	0	67.00
69.00	06900	ELECTROCARDIOLOGY	348,994	286	143,855	4,308	39,934	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	82,946	43	24,490	139	5,898	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	3,017,105	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	1,582,582	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,583,652	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	14,836	28	16,028	0	3,871	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01	03650	VASCULAR LAB	121,243	39	35,247	8,867	5,468	76.01
76.03	03950	WOUND CARE	430,172	214	123,955	7,393	29,981	76.03
76.97	07697	CARDIAC REHABILITATION	45,802	42	23,665	828	5,714	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	75,265	60	34,816	1,317	8,417	90.00
91.00	09100	EMERGENCY	1,105,537	610	350,675	129,704	85,397	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	3,535,960	303	175,768	0	42,576	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	847,664	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,282,088	14,349	6,325,804	776,049	1,471,230	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	9,167	34	18,932	0	4,731	190.00
194.00	07950	PHILANTHROPY DEVELOPMENT	1,356,524	194	0	201	27,032	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	1,604	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	31,647,779	14,577	6,344,736	777,854	1,502,993	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 14-0032	Period: From 07/01/2017 To 06/30/2018	Worksheet B Part I Date/Time Prepared: 11/26/2018 3:39 pm				
Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY		
		10.00	11.00	13.00	14.00	15.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
6.00	00600	MAINTENANCE & REPAIRS					6.00	
7.00	00700	OPERATION OF PLANT					7.00	
8.00	00800	LAUNDRY & LINEN SERVICE					8.00	
9.00	00900	HOUSEKEEPING					9.00	
10.00	01000	DIETARY	1,070,184				10.00	
11.00	01100	CAFETERIA	0	1,604,064			11.00	
13.00	01300	NURSING ADMINISTRATION	0	30,462	2,251,743		13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	0	527	0	195,287	14.00	
15.00	01500	PHARMACY	0	37,838	0	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	31,647	0	5	16.00	
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	947,251	370,641	852,320	2,527	10,538	30.00
31.00	03100	INTENSIVE CARE UNIT	122,933	74,038	154,068	435	1,417	31.00
43.00	04300	NURSERY	0	10,236	0	129	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	182,697	380,234	116,100	6,348	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	28,656	0	749	0	52.00
53.00	05300	ANESTHESIOLOGY	0	27,056	0	1,931	14,454	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	76,861	0	2,818	2,786	54.00
54.01	03630	ULTRA SOUND	0	10,819	0	522	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	7,037	0	3,244	11,684	54.02
54.06	05404	PET SCAN	0	0	0	0	0	54.06
57.00	05700	CT SCAN	0	21,092	0	1,413	0	57.00
58.00	05800	MRI	0	8,636	0	594	578	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	16,445	0	9,686	1,618	59.00
60.00	06000	LABORATORY	0	74,358	0	20,611	8,851	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	42,128	0	1,740	13	65.00
66.00	06600	PHYSICAL THERAPY	0	47,151	0	164	58	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,418	0	266	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	27,847	0	259	646	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,978	0	343	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	18,309	2,523	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,090	2,858,245	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	36	0	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01	03650	VASCULAR LAB	0	13,171	0	41	0	76.01
76.03	03950	WOUND CARE	0	15,654	0	1,213	5,602	76.03
76.97	07697	CARDIAC REHABILITATION	0	2,709	0	18	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	8,373	0	0	0	90.00
91.00	09100	EMERGENCY	0	130,259	271,083	1,623	4,038	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	231,711	482,215	5,419	157,053	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	53,737	111,823	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,070,184	1,602,182	2,251,743	195,285	3,086,452	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
194.00	07950	PHILANTHROPY DEVELOPMENT	0	1,882	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	2	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,070,184	1,604,064	2,251,743	195,287	3,086,452	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 14-0032	Period: From 07/01/2017 To 06/30/2018	Worksheet B Part I Date/Time Prepared: 11/26/2018 3:39 pm
Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total
	16.00	17.00	24.00	25.00	26.00
GENERAL SERVICE COST CENTERS					
1.00 00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00 00500	ADMINISTRATIVE & GENERAL				5.00
6.00 00600	MAINTENANCE & REPAIRS				6.00
7.00 00700	OPERATION OF PLANT				7.00
8.00 00800	LAUNDRY & LINEN SERVICE				8.00
9.00 00900	HOUSEKEEPING				9.00
10.00 01000	DIETARY				10.00
11.00 01100	CAFETERIA				11.00
13.00 01300	NURSING ADMINISTRATION				13.00
14.00 01400	CENTRAL SERVICES & SUPPLY				14.00
15.00 01500	PHARMACY				15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	6,385,079			16.00
17.00 01700	SOCIAL SERVICE	0	122		17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	5,658,530	108	19,628,142	30.00
31.00 03100	INTENSIVE CARE UNIT	726,549	14	3,862,140	31.00
43.00 04300	NURSERY	0	0	738,916	43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	0	0	12,620,403	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	2,365,461	52.00
53.00 05300	ANESTHESIOLOGY	0	0	1,455,342	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	5,545,684	54.00
54.01 03630	ULTRA SOUND	0	0	503,375	54.01
54.02 03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	882,780	54.02
54.06 05404	PET SCAN	0	0	174,025	54.06
57.00 05700	CT SCAN	0	0	1,154,772	57.00
58.00 05800	MRI	0	0	1,078,269	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	993,580	59.00
60.00 06000	LABORATORY	0	0	4,280,234	60.00
62.30 06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	0	0	1,139,434	65.00
66.00 06600	PHYSICAL THERAPY	0	0	3,632,239	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	766,181	67.00
69.00 06900	ELECTROCARDIOLOGY	0	0	1,546,092	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	354,746	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	11,509,857	71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	6,026,414	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	8,893,825	73.00
74.00 07400	RENAL DIALYSIS	0	0	76,458	74.00
76.00 03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	76.00
76.01 03650	VASCULAR LAB	0	0	524,522	76.01
76.03 03950	WOUND CARE	0	0	1,822,091	76.03
76.97 07697	CARDIAC REHABILITATION	0	0	207,387	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00 09000	CLINIC	0	0	339,590	90.00
91.00 09100	EMERGENCY	0	0	5,183,234	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
101.00 10100	HOME HEALTH AGENCY	0	0	14,559,870	101.00
SPECIAL PURPOSE COST CENTERS					
113.00 11300	INTEREST EXPENSE				113.00
116.00 11600	HOSPICE	0	0	3,393,433	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	6,385,079	122	115,258,496	118.00
NONREIMBURSABLE COST CENTERS					
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	58,604	190.00
194.00 07950	PHILANTHROPY DEVELOPMENT	0	0	5,194,904	194.00
194.01 07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.01
194.02 07952	MEALS ON WHEELS	0	0	0	194.02
194.03 07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	1,606	194.03
200.00	Cross Foot Adjustments			0	200.00
201.00	Negative Cost Centers	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	6,385,079	122	120,513,610	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0032	Period: From 07/01/2017 To 06/30/2018	Worksheet B Part II Date/Time Prepared: 11/26/2018 3:39 pm
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,127	0	5,127	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	2,379,011	605,080	0	2,984,091	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	986	986	6.00
7.00 00700	OPERATION OF PLANT	1,325	436,152	1,228,763	1,666,240	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	11,809	1,362	13,171	8.00
9.00 00900	HOUSEKEEPING	0	0	2,256	2,256	9.00
10.00 01000	DIETARY	-18	50,792	12,482	63,256	10.00
11.00 01100	CAFETERIA	0	11,657	0	11,657	11.00
13.00 01300	NURSING ADMINISTRATION	0	19,488	2,027	21,515	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	18,584	0	18,584	14.00
15.00 01500	PHARMACY	254,375	27,161	7,669	289,205	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	49,910	7,625	57,535	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,341	300,277	122,685	424,303	30.00
31.00 03100	INTENSIVE CARE UNIT	0	31,839	56,676	88,515	31.00
43.00 04300	NURSERY	0	0	3,034	3,034	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	412,280	225,326	536,364	1,173,970	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	32,309	31,622	63,931	52.00
53.00 05300	ANESTHESIOLOGY	0	1,417	41,343	42,760	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	150,021	118,795	290,010	558,826	54.00
54.01 03630	ULTRA SOUND	0	3,963	42,786	46,749	54.01
54.02 03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	17,579	819	18,398	54.02
54.06 05404	PET SCAN	0	0	0	0	54.06
57.00 05700	CT SCAN	0	10,131	1,528	11,659	57.00
58.00 05800	MRI	0	38,543	13,939	52,482	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	13,392	16,287	29,679	59.00
60.00 06000	LABORATORY	94,936	42,390	45,256	182,582	60.00
62.30 06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	26	5,279	4,704	10,009	65.00
66.00 06600	PHYSICAL THERAPY	11,887	57,850	12,209	81,946	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
69.00 06900	ELECTROCARDIOLOGY	0	29,012	70,649	99,661	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	6,551	4,939	5,071	16,561	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	3,232	0	3,232	74.00
76.00 03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	76.00
76.01 03650	VASCULAR LAB	0	7,108	22,625	29,733	76.01
76.03 03950	WOUND CARE	0	24,998	4,537	29,535	76.03
76.97 07697	CARDIAC REHABILITATION	0	4,773	797	5,570	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	7,022	1,758	8,780	90.00
91.00 09100	EMERGENCY	0	70,722	30,676	101,398	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)				0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	29,985	35,448	80,474	145,907	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE	0	0	1,653	1,653	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	3,341,720	2,322,104	2,700,672	8,364,496	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	0	3,818	514	4,332	190.00
194.00 07950	PHILANTHROPY DEVELOPMENT	0	0	75,304	75,304	194.00
194.01 07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.01
194.02 07952	MEALS ON WHEELS	0	0	0	0	194.02
194.03 07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.03
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers				0	201.00
202.00	TOTAL (sum lines 118 through 201)	3,341,720	2,325,922	2,776,490	8,444,132	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0032	Period: From 07/01/2017 To 06/30/2018	Worksheet B Part II Date/Time Prepared: 11/26/2018 3:39 pm		
Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING
			5.00	6.00	7.00	8.00	9.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,984,629				5.00
6.00	00600	MAINTENANCE & REPAIRS	361	1,347			6.00
7.00	00700	OPERATION OF PLANT	157,041	343	1,823,727		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,812	9	16,831	47,829	8.00
9.00	00900	HOUSEKEEPING	37,223	0	0	0	39,555 9.00
10.00	01000	DIETARY	18,608	40	72,393	344	1,604 10.00
11.00	01100	CAFETERIA	37,945	9	16,614	0	369 11.00
13.00	01300	NURSING ADMINISTRATION	52,196	11	27,776	0	446 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,985	15	26,488	0	587 14.00
15.00	01500	PHARMACY	71,353	22	38,711	0	859 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	150,771	12	71,136	0	474 16.00
17.00	01700	SOCIAL SERVICE	3	0	0	0	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	240,190	238	427,976	14,506	9,486 30.00
31.00	03100	INTENSIVE CARE UNIT	63,218	25	45,380	2,074	1,006 31.00
43.00	04300	NURSERY	18,043	0	0	0	0 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	256,109	178	321,151	12,611	7,095 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	51,539	26	46,049	3,430	1,020 52.00
53.00	05300	ANESTHESIOLOGY	34,750	1	2,020	0	45 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	116,390	94	169,315	1,904	3,753 54.00
54.01	03630	ULTRA SOUND	11,485	3	5,648	238	124 54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	18,569	14	25,055	163	555 54.02
54.06	05404	PET SCAN	4,310	0	0	0	0 54.06
57.00	05700	CT SCAN	26,249	8	14,439	608	320 57.00
58.00	05800	MRI	20,023	31	54,934	1,370	1,218 58.00
59.00	05900	CARDIAC CATHETERIZATION	21,869	11	19,088	13	424 59.00
60.00	06000	LABORATORY	96,959	34	60,417	0	1,339 60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	26,143	5	7,524	402	189 65.00
66.00	06600	PHYSICAL THERAPY	79,739	46	82,452	518	1,827 66.00
67.00	06700	OCCUPATIONAL THERAPY	18,598	0	0	156	0 67.00
69.00	06900	ELECTROCARDIOLOGY	32,913	26	41,350	265	1,051 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,822	4	7,039	9	155 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	284,538	0	0	0	0 71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	149,251	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	149,352	0	0	0	0 73.00
74.00	07400	RENAL DIALYSIS	1,399	3	4,607	0	102 74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0 76.00
76.01	03650	VASCULAR LAB	11,434	4	10,131	545	144 76.01
76.03	03950	WOUND CARE	40,569	20	35,630	455	789 76.03
76.97	07697	CARDIAC REHABILITATION	4,319	4	6,802	51	150 76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	7,098	6	10,008	81	222 90.00
91.00	09100	EMERGENCY	104,261	56	100,798	7,975	2,247 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	333,454	28	50,523	0	1,120 101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	79,942	0	0	0	0 116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,855,833	1,326	1,818,285	47,718	38,720 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	865	3	5,442	0	124 190.00
194.00	07950	PHILANTHROPY DEVELOPMENT	127,931	18	0	12	711 194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0 194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	99	0 194.03
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	2,984,629	1,347	1,823,727	47,829	39,555 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0032	Period: From 07/01/2017 To 06/30/2018	Worksheet B Part II Date/Time Prepared: 11/26/2018 3:39 pm				
Cost Center	Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY		
		10.00	11.00	13.00	14.00	15.00		
GENERAL SERVICE COST CENTERS								
1.00	00100						1.00	
2.00	00200						2.00	
4.00	00400						4.00	
5.00	00500						5.00	
6.00	00600						6.00	
7.00	00700						7.00	
8.00	00800						8.00	
9.00	00900						9.00	
10.00	01000	156,280					10.00	
11.00	01100	0	66,653				11.00	
13.00	01300	0	1,266	103,342			13.00	
14.00	01400	0	22	0	47,682		14.00	
15.00	01500	0	1,572	0	0	401,874	15.00	
16.00	01600	0	1,315	0	1	0	16.00	
17.00	01700	0	0	0	0	0	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	138,328	15,402	39,117	617	1,372	30.00	
31.00	03100	17,952	3,076	7,071	106	185	31.00	
43.00	04300	0	425	0	32	0	43.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	0	7,592	17,450	28,350	827	50.00	
52.00	05200	0	1,191	0	183	0	52.00	
53.00	05300	0	1,124	0	471	1,882	53.00	
54.00	05400	0	3,194	0	688	363	54.00	
54.01	03630	0	450	0	127	0	54.01	
54.02	03450	0	292	0	792	1,521	54.02	
54.06	05404	0	0	0	0	0	54.06	
57.00	05700	0	876	0	345	0	57.00	
58.00	05800	0	359	0	145	75	58.00	
59.00	05900	0	683	0	2,365	211	59.00	
60.00	06000	0	3,090	0	5,032	1,152	60.00	
62.30	06250	0	0	0	0	0	62.30	
65.00	06500	0	1,751	0	425	2	65.00	
66.00	06600	0	1,959	0	40	8	66.00	
67.00	06700	0	516	0	65	0	67.00	
69.00	06900	0	1,157	0	63	84	69.00	
70.00	07000	0	331	0	84	0	70.00	
71.00	07100	0	0	0	4,470	328	71.00	
72.00	07200	0	0	0	0	0	72.00	
73.00	07300	0	0	0	1,243	372,160	73.00	
74.00	07400	0	0	0	9	0	74.00	
76.00	03050	0	0	0	0	0	76.00	
76.01	03650	0	547	0	10	0	76.01	
76.03	03950	0	650	0	296	729	76.03	
76.97	07697	0	113	0	4	0	76.97	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	0	348	0	0	0	90.00	
91.00	09100	0	5,413	12,441	396	526	91.00	
92.00	09200	0	0	0	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	0	9,628	22,131	1,323	20,449	101.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300	0	0	0	0	0	113.00	
116.00	11600	0	2,233	5,132	0	0	116.00	
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		156,280	66,575	103,342	47,682	401,874	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	0	0	0	0	0	190.00	
194.00	07950	0	78	0	0	0	194.00	
194.01	07951	0	0	0	0	0	194.01	
194.02	07952	0	0	0	0	0	194.02	
194.03	07953	0	0	0	0	0	194.03	
200.00	Cross Foot Adjustments		0	0	0	0	200.00	
201.00	Negative Cost Centers		0	0	0	0	201.00	
202.00	TOTAL (sum lines 118 through 201)		156,280	66,653	103,342	47,682	401,874	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0032	Period: From 07/01/2017 To 06/30/2018	Worksheet B Part II Date/Time Prepared: 11/26/2018 3:39 pm
Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total
	16.00	17.00	24.00	25.00	26.00
GENERAL SERVICE COST CENTERS					
1.00 00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00 00500	ADMINISTRATIVE & GENERAL				5.00
6.00 00600	MAINTENANCE & REPAIRS				6.00
7.00 00700	OPERATION OF PLANT				7.00
8.00 00800	LAUNDRY & LINEN SERVICE				8.00
9.00 00900	HOUSEKEEPING				9.00
10.00 01000	DIETARY				10.00
11.00 01100	CAFETERIA				11.00
13.00 01300	NURSING ADMINISTRATION				13.00
14.00 01400	CENTRAL SERVICES & SUPPLY				14.00
15.00 01500	PHARMACY				15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	281,527			16.00
17.00 01700	SOCIAL SERVICE	0	3		17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	249,492	3	1,561,568	30.00
31.00 03100	INTENSIVE CARE UNIT	32,035	0	260,800	31.00
43.00 04300	NURSERY	0	0	21,580	43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	0	0	1,825,824	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	167,499	52.00
53.00 05300	ANESTHESIOLOGY	0	0	83,316	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	854,727	54.00
54.01 03630	ULTRA SOUND	0	0	64,844	54.01
54.02 03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	65,380	54.02
54.06 05404	PET SCAN	0	0	4,310	54.06
57.00 05700	CT SCAN	0	0	54,542	57.00
58.00 05800	MRI	0	0	130,663	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	74,389	59.00
60.00 06000	LABORATORY	0	0	350,762	60.00
62.30 06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	0	0	46,510	65.00
66.00 06600	PHYSICAL THERAPY	0	0	248,707	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	19,383	67.00
69.00 06900	ELECTROCARDIOLOGY	0	0	176,637	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	32,024	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	289,336	71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	149,251	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	522,755	73.00
74.00 07400	RENAL DIALYSIS	0	0	9,352	74.00
76.00 03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	76.00
76.01 03650	VASCULAR LAB	0	0	52,573	76.01
76.03 03950	WOUND CARE	0	0	108,727	76.03
76.97 07697	CARDIAC REHABILITATION	0	0	17,024	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00 09000	CLINIC	0	0	26,561	90.00
91.00 09100	EMERGENCY	0	0	335,729	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
101.00 10100	HOME HEALTH AGENCY	0	0	585,331	101.00
SPECIAL PURPOSE COST CENTERS					
113.00 11300	INTEREST EXPENSE				113.00
116.00 11600	HOSPICE	0	0	89,098	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	281,527	3	8,229,202	118.00
NONREIMBURSABLE COST CENTERS					
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	10,766	190.00
194.00 07950	PHILANTHROPY DEVELOPMENT	0	0	204,065	194.00
194.01 07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.01
194.02 07952	MEALS ON WHEELS	0	0	0	194.02
194.03 07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	99	194.03
200.00	Cross Foot Adjustments			0	200.00
201.00	Negative Cost Centers	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	281,527	3	8,444,132	202.00

COST ALLOCATION - STATISTICAL BASIS			Provider CCN: 14-0032	Period: From 07/01/2017 To 06/30/2018	Worksheet B-1 Date/Time Prepared: 11/26/2018 3:39 pm	
Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	321,649				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		4,621,793			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	709	0	43,436,201		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	83,676	0	4,562,945	-31,647,779	88,865,831
6.00 00600	MAINTENANCE & REPAIRS	0	1,642	0	0	10,749
7.00 00700	OPERATION OF PLANT	60,315	2,045,419	872,523	0	4,675,800
8.00 00800	LAUNDRY & LINEN SERVICE	1,633	2,267	48,967	0	530,333
9.00 00900	HOUSEKEEPING	0	3,755	643,493	0	1,108,296
10.00 01000	DIETARY	7,024	20,778	298,699	0	554,043
11.00 01100	CAFETERIA	1,612	0	499,037	0	1,129,801
13.00 01300	NURSING ADMINISTRATION	2,695	3,374	1,122,177	0	1,554,106
14.00 01400	CENTRAL SERVICES & SUPPLY	2,570	0	8,860	0	59,100
15.00 01500	PHARMACY	3,756	12,766	1,285,294	0	2,124,488
16.00 01600	MEDICAL RECORDS & LIBRARY	6,902	12,693	2,401,145	0	4,489,111
17.00 01700	SOCIAL SERVICE	0	0	0	0	90
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	41,525	204,224	4,559,021	0	7,151,482
31.00 03100	INTENSIVE CARE UNIT	4,403	94,344	1,329,089	0	1,882,264
43.00 04300	NURSERY	0	5,051	393,770	0	537,228
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	31,160	892,840	4,159,042	0	7,625,478
52.00 05200	DELIVERY ROOM & LABOR ROOM	4,468	52,638	1,102,893	0	1,534,533
53.00 05300	ANESTHESIOLOGY	196	68,821	2,225,073	0	1,034,665
54.00 05400	RADIOLOGY-DIAGNOSTIC	16,428	482,755	1,698,278	0	3,465,444
54.01 03630	ULTRA SOUND	548	71,222	171,671	0	341,971
54.02 03450	NUCLEAR MEDICINE - DIAGNOSTIC	2,431	1,363	174,057	0	552,881
54.06 05404	PET SCAN	0	0	0	0	128,325
57.00 05700	CT SCAN	1,401	2,543	320,329	0	781,552
58.00 05800	MRI	5,330	23,203	219,066	0	596,162
59.00 05900	CARDIAC CATHETERIZATION	1,852	27,112	393,067	0	651,122
60.00 06000	LABORATORY	5,862	75,334	1,330,210	0	2,886,885
62.30 06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	730	7,831	509,407	0	778,388
66.00 06600	PHYSICAL THERAPY	8,000	20,324	1,460,062	0	2,374,161
67.00 06700	OCCUPATIONAL THERAPY	0	0	409,879	0	553,755
69.00 06900	ELECTROCARDIOLOGY	4,012	117,603	571,364	0	979,963
70.00 07000	ELECTROENCEPHALOGRAPHY	683	8,442	162,171	0	232,909
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	8,471,920
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	4,443,832
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	4,446,838
74.00 07400	RENAL DIALYSIS	447	0	0	0	41,659
76.00 03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0
76.01 03650	VASCULAR LAB	983	37,662	210,521	0	340,446
76.03 03950	WOUND CARE	3,457	7,553	453,998	0	1,207,907
76.97 07697	CARDIAC REHABILITATION	660	1,326	92,025	0	128,609
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	971	2,927	152,117	0	211,342
91.00 09100	EMERGENCY	9,780	51,064	1,847,967	0	3,104,308
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)					
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	4,902	133,958	6,484,449	0	9,928,865
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
116.00 11600	HOSPICE	0	2,751	1,169,621	0	2,380,209
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	321,121	4,495,585	43,342,287	-31,647,779	85,031,020
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	528	855	0	0	25,740
194.00 07950	PHILANTHROPY DEVELOPMENT	0	125,353	93,914	0	3,809,071
194.01 07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.02 07952	MEALS ON WHEELS	0	0	0	0	0
194.03 07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	2,325,922	2,776,490	14,309,888		31,647,779
203.00	Unit cost multiplier (Wkst. B, Part I)	7.231243	0.600739	0.329446		0.356130

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0032

Period:
From 07/01/2017
To 06/30/2018

Worksheet B-1

Date/Time Prepared:
11/26/2018 3:39 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
204.00	Cost to be allocated (per Wkst. B, Part II)		5,127		2,984,629	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)		0.000118		0.033586	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: 14-0032

Period:
From 07/01/2017
To 06/30/2018

Worksheet B-1

Date/Time Prepared:
11/26/2018 3:39 pm

Cost Center Description		MAINTENANCE & REPAIRS (MAINT. HOURS)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	11,590					6.00
7.00	00700	2,978	176,949				7.00
8.00	00800	80	1,633	778,915			8.00
9.00	00900	0	0	0	24,464		9.00
10.00	01000	346	7,024	5,603	992	54,400	10.00
11.00	01100	79	1,612	0	228	0	11.00
13.00	01300	96	2,695	0	276	0	13.00
14.00	01400	127	2,570	0	363	0	14.00
15.00	01500	185	3,756	0	531	0	15.00
16.00	01600	102	6,902	0	293	0	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	2,045	41,525	236,259	5,867	48,151	30.00
31.00	03100	217	4,403	33,775	622	6,249	31.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,530	31,160	205,374	4,388	0	50.00
52.00	05200	220	4,468	55,856	631	0	52.00
53.00	05300	10	196	0	28	0	53.00
54.00	05400	809	16,428	31,009	2,321	0	54.00
54.01	03630	27	548	3,868	77	0	54.01
54.02	03450	120	2,431	2,649	343	0	54.02
54.06	05404	0	0	0	0	0	54.06
57.00	05700	69	1,401	9,907	198	0	57.00
58.00	05800	263	5,330	22,311	753	0	58.00
59.00	05900	91	1,852	209	262	0	59.00
60.00	06000	289	5,862	0	828	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	41	730	6,552	117	0	65.00
66.00	06600	394	8,000	8,436	1,130	0	66.00
67.00	06700	0	0	2,536	0	0	67.00
69.00	06900	227	4,012	4,314	650	0	69.00
70.00	07000	34	683	139	96	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	22	447	0	63	0	74.00
76.00	03050	0	0	0	0	0	76.00
76.01	03650	31	983	8,879	89	0	76.01
76.03	03950	170	3,457	7,403	488	0	76.03
76.97	07697	33	660	829	93	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	48	971	1,319	137	0	90.00
91.00	09100	485	9,780	129,881	1,390	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	241	4,902	0	693	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	0	0	0	0	0	116.00
118.00							118.00
		11,409	176,421	777,108	23,947	54,400	
NONREIMBURSABLE COST CENTERS							
190.00	19000	27	528	0	77	0	190.00
194.00	07950	154	0	201	440	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	1,606	0	0	194.03
200.00							200.00
201.00							201.00
202.00		14,577	6,344,736	777,854	1,502,993	1,070,184	202.00
203.00		1.257722	35.856298	0.998638	61.436928	19.672500	203.00
204.00		1,347	1,823,727	47,829	39,555	156,280	204.00
205.00		0.116221	10.306512	0.061405	1.616866	2.872794	205.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 14-0032			Period: From 07/01/2017 To 06/30/2018		Worksheet B-1 Date/Time Prepared: 11/26/2018 3:39 pm	
Cost Center Description		MAINTENANCE & REPAIRS (MAINT. HOURS)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)		
		6.00	7.00	8.00	9.00	10.00		
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: 14-0032		Period: From 07/01/2017 To 06/30/2018		Worksheet B-1	
Date/Time Prepared: 11/26/2018 3:39 pm							
Cost Center	Description	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	85,253					11.00
13.00	01300	1,619	1,196,082				13.00
14.00	01400	28	0	13,912,354			14.00
15.00	01500	2,011	0	0	4,172,332		15.00
16.00	01600	1,682	0	334	0	10,001	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	19,699	452,736	180,040	14,245	8,863	30.00
31.00	03100	3,935	81,838	30,960	1,916	1,138	31.00
43.00	04300	544	0	9,196	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	9,710	201,973	8,271,280	8,581	0	50.00
52.00	05200	1,523	0	53,358	0	0	52.00
53.00	05300	1,438	0	137,563	19,539	0	53.00
54.00	05400	4,085	0	200,733	3,766	0	54.00
54.01	03630	575	0	37,170	0	0	54.01
54.02	03450	374	0	231,080	15,795	0	54.02
54.06	05404	0	0	0	0	0	54.06
57.00	05700	1,121	0	100,668	0	0	57.00
58.00	05800	459	0	42,290	782	0	58.00
59.00	05900	874	0	690,042	2,187	0	59.00
60.00	06000	3,952	0	1,468,340	11,965	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	2,239	0	123,947	18	0	65.00
66.00	06600	2,506	0	11,701	78	0	66.00
67.00	06700	660	0	18,956	0	0	67.00
69.00	06900	1,480	0	18,419	873	0	69.00
70.00	07000	424	0	24,436	0	0	70.00
71.00	07100	0	0	1,304,307	3,410	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	362,613	3,863,839	0	73.00
74.00	07400	0	0	2,545	0	0	74.00
76.00	03050	0	0	0	0	0	76.00
76.01	03650	700	0	2,910	0	0	76.01
76.03	03950	832	0	86,425	7,573	0	76.03
76.97	07697	144	0	1,294	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	445	0	0	0	0	90.00
91.00	09100	6,923	143,994	115,593	5,458	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	12,315	256,143	386,046	212,307	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	2,856	59,398	0	0	0	116.00
118.00		85,153	1,196,082	13,912,246	4,172,332	10,001	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	100	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	108	0	0	194.03
200.00							200.00
201.00							201.00
202.00		1,604,064	2,251,743	195,287	3,086,452	6,385,079	202.00
203.00		18.815338	1.882599	0.014037	0.739743	638.444056	203.00
204.00		66,653	103,342	47,682	401,874	281,527	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0032

Period:
From 07/01/2017
To 06/30/2018

Worksheet B-1

Date/Time Prepared:
11/26/2018 3:39 pm

Cost Center Description		CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	0.781826	0.086400	0.003427	0.096319	28.149885	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: 14-0032

Period:
From 07/01/2017
To 06/30/2018

Worksheet B-1
Date/Time Prepared:
11/26/2018 3:39 pm

Cost Center Description		SOCIAL SERVICE (TIME SPENT)	
		17.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
		10,001	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
43.00	04300	NURSERY	43.00
		8,863	
		1,138	
		0	
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	03630	ULTRA SOUND	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	54.02
54.06	05404	PET SCAN	54.06
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
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
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	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	76.00
76.01	03650	VASCULAR LAB	76.01
76.03	03950	WOUND CARE	76.03
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
116.00	11600	HOSPICE	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
		10,001	
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	190.00
194.00	07950	PHILANTHROPY DEVELOPMENT	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	194.01
194.02	07952	MEALS ON WHEELS	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	194.03
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	202.00
		122	
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
		0.012199	
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
		3	
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00
		0.000300	

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 14-0032	Period: From 07/01/2017 To 06/30/2018	Worksheet B-1 Date/Time Prepared: 11/26/2018 3:39 pm
Cost Center Description		SOCIAL SERVICE (TIME SPENT)		
		17.00		
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)			206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)			207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0032	Period: From 07/01/2017 To 06/30/2018	Worksheet C Part I Date/Time Prepared: 11/26/2018 3:39 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	19,628,142		19,628,142	0	19,628,142	30.00
31.00	03100 INTENSIVE CARE UNIT	3,862,140		3,862,140	0	3,862,140	31.00
43.00	04300 NURSERY	738,916		738,916	0	738,916	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	12,620,403		12,620,403	0	12,620,403	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2,365,461		2,365,461	0	2,365,461	52.00
53.00	05300 ANESTHESIOLOGY	1,455,342		1,455,342	0	1,455,342	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,545,684		5,545,684	0	5,545,684	54.00
54.01	03630 ULTRA SOUND	503,375		503,375	0	503,375	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	882,780		882,780	0	882,780	54.02
54.06	05404 PET SCAN	174,025		174,025	0	174,025	54.06
57.00	05700 CT SCAN	1,154,772		1,154,772	0	1,154,772	57.00
58.00	05800 MRI	1,078,269		1,078,269	0	1,078,269	58.00
59.00	05900 CARDIAC CATHETERIZATION	993,580		993,580	0	993,580	59.00
60.00	06000 LABORATORY	4,280,234		4,280,234	0	4,280,234	60.00
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0		0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	1,139,434	0	1,139,434	0	1,139,434	65.00
66.00	06600 PHYSICAL THERAPY	3,632,239	0	3,632,239	0	3,632,239	66.00
67.00	06700 OCCUPATIONAL THERAPY	766,181	0	766,181	0	766,181	67.00
69.00	06900 ELECTROCARDIOLOGY	1,546,092		1,546,092	0	1,546,092	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	354,746		354,746	0	354,746	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	11,509,857		11,509,857	0	11,509,857	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	6,026,414		6,026,414	0	6,026,414	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	8,893,825		8,893,825	0	8,893,825	73.00
74.00	07400 RENAL DIALYSIS	76,458		76,458	0	76,458	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0		0	0	0	76.00
76.01	03650 VASCULAR LAB	524,522		524,522	0	524,522	76.01
76.03	03950 WOUND CARE	1,822,091		1,822,091	6,675	1,828,766	76.03
76.97	07697 CARDIAC REHABILITATION	207,387		207,387	0	207,387	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	339,590		339,590	0	339,590	90.00
91.00	09100 EMERGENCY	5,183,234		5,183,234	0	5,183,234	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	2,194,974		2,194,974		2,194,974	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100 HOME HEALTH AGENCY	14,559,870		14,559,870		14,559,870	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
116.00	11600 HOSPICE	3,393,433		3,393,433		3,393,433	116.00
200.00	Subtotal (see instructions)	117,453,470	0	117,453,470	6,675	117,460,145	200.00
201.00	Less Observation Beds	2,194,974		2,194,974		2,194,974	201.00
202.00	Total (see instructions)	115,258,496	0	115,258,496	6,675	115,265,171	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0032		Period: From 07/01/2017 To 06/30/2018		Worksheet C Part I Date/Time Prepared: 11/26/2018 3:39 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	12,764,655		12,764,655				30.00
31.00	03100	INTENSIVE CARE UNIT	2,940,995		2,940,995				31.00
43.00	04300	NURSERY	1,190,941		1,190,941				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	13,064,823	39,763,449	52,828,272	0.238895	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,166,192	560,128	3,726,320	0.634798	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	3,382,862	6,332,386	9,715,248	0.149800	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,659,730	17,177,326	19,837,056	0.279562	0.000000		54.00
54.01	03630	ULTRA SOUND	406,148	3,285,581	3,691,729	0.136352	0.000000		54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	574,414	9,307,591	9,882,005	0.089332	0.000000		54.02
54.06	05404	PET SCAN	0	1,222,630	1,222,630	0.142337	0.000000		54.06
57.00	05700	CT SCAN	5,829,399	32,004,802	37,834,201	0.030522	0.000000		57.00
58.00	05800	MRI	850,768	15,959,147	16,809,915	0.064145	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	1,112,949	6,672,643	7,785,592	0.127618	0.000000		59.00
60.00	06000	LABORATORY	7,051,841	13,979,796	21,031,637	0.203514	0.000000		60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0.000000	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	2,169,127	736,616	2,905,743	0.392132	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	1,473,429	5,310,284	6,783,713	0.535435	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	751,978	2,130,137	2,882,115	0.265840	0.000000		67.00
69.00	06900	ELECTROCARDIOLOGY	2,035,895	9,729,597	11,765,492	0.131409	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	10,208	2,613,622	2,623,830	0.135202	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	14,628,263	18,473,578	33,101,841	0.347710	0.000000		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	13,247,854	5,041,158	18,289,012	0.329510	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,629,955	18,832,942	37,462,897	0.237404	0.000000		73.00
74.00	07400	RENAL DIALYSIS	90,287	3,451	93,738	0.815656	0.000000		74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0.000000	0.000000		76.00
76.01	03650	VASCULAR LAB	252,542	2,996,041	3,248,583	0.161462	0.000000		76.01
76.03	03950	WOUND CARE	48,902	5,656,844	5,705,746	0.319343	0.000000		76.03
76.97	07697	CARDIAC REHABILITATION	215	705,264	705,479	0.293966	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	830	510,570	511,400	0.664040	0.000000		90.00
91.00	09100	EMERGENCY	4,009,849	19,610,844	23,620,693	0.219436	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	566,003	2,101,997	2,668,000	0.822704	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
101.00	10100	HOME HEALTH AGENCY	0	10,557,299	10,557,299				101.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
116.00	11600	HOSPICE	0	8,063,525	8,063,525				116.00
200.00		Subtotal (see instructions)	112,911,054	259,339,248	372,250,302				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	112,911,054	259,339,248	372,250,302				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0032	Period: From 07/01/2017 To 06/30/2018	Worksheet C Part I Date/Time Prepared: 11/26/2018 3:39 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital
		11.00		PPS
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.238895	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.634798	52.00
53.00	05300	ANESTHESIOLOGY	0.149800	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.279562	54.00
54.01	03630	ULTRA SOUND	0.136352	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.089332	54.02
54.06	05404	PET SCAN	0.142337	54.06
57.00	05700	CT SCAN	0.030522	57.00
58.00	05800	MRI	0.064145	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.127618	59.00
60.00	06000	LABORATORY	0.203514	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0.392132	65.00
66.00	06600	PHYSICAL THERAPY	0.535435	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.265840	67.00
69.00	06900	ELECTROCARDIOLOGY	0.131409	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.135202	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.347710	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.329510	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.237404	73.00
74.00	07400	RENAL DIALYSIS	0.815656	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0.000000	76.00
76.01	03650	VASCULAR LAB	0.161462	76.01
76.03	03950	WOUND CARE	0.320513	76.03
76.97	07697	CARDIAC REHABILITATION	0.293966	76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.664040	90.00
91.00	09100	EMERGENCY	0.219436	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0.822704	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
116.00	11600	HOSPICE		116.00
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: 14-0032

Period:
From 07/01/2017
To 06/30/2018

Worksheet C
Part I
Date/Time Prepared:
11/26/2018 3:39 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	19,628,142		19,628,142	0	19,628,142	30.00
31.00	03100 INTENSIVE CARE UNIT	3,862,140		3,862,140	0	3,862,140	31.00
43.00	04300 NURSERY	738,916		738,916	0	738,916	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	12,620,403		12,620,403	0	12,620,403	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2,365,461		2,365,461	0	2,365,461	52.00
53.00	05300 ANESTHESIOLOGY	1,455,342		1,455,342	0	1,455,342	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,545,684		5,545,684	0	5,545,684	54.00
54.01	03630 ULTRA SOUND	503,375		503,375	0	503,375	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	882,780		882,780	0	882,780	54.02
54.06	05404 PET SCAN	174,025		174,025	0	174,025	54.06
57.00	05700 CT SCAN	1,154,772		1,154,772	0	1,154,772	57.00
58.00	05800 MRI	1,078,269		1,078,269	0	1,078,269	58.00
59.00	05900 CARDIAC CATHETERIZATION	993,580		993,580	0	993,580	59.00
60.00	06000 LABORATORY	4,280,234		4,280,234	0	4,280,234	60.00
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0		0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	1,139,434	0	1,139,434	0	1,139,434	65.00
66.00	06600 PHYSICAL THERAPY	3,632,239	0	3,632,239	0	3,632,239	66.00
67.00	06700 OCCUPATIONAL THERAPY	766,181	0	766,181	0	766,181	67.00
69.00	06900 ELECTROCARDIOLOGY	1,546,092		1,546,092	0	1,546,092	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	354,746		354,746	0	354,746	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	11,509,857		11,509,857	0	11,509,857	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	6,026,414		6,026,414	0	6,026,414	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	8,893,825		8,893,825	0	8,893,825	73.00
74.00	07400 RENAL DIALYSIS	76,458		76,458	0	76,458	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0		0	0	0	76.00
76.01	03650 VASCULAR LAB	524,522		524,522	0	524,522	76.01
76.03	03950 WOUND CARE	1,822,091		1,822,091	6,675	1,828,766	76.03
76.97	07697 CARDIAC REHABILITATION	207,387		207,387	0	207,387	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	339,590		339,590	0	339,590	90.00
91.00	09100 EMERGENCY	5,183,234		5,183,234	0	5,183,234	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	2,194,974		2,194,974		2,194,974	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100 HOME HEALTH AGENCY	14,559,870		14,559,870		14,559,870	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
116.00	11600 HOSPICE	3,393,433		3,393,433		3,393,433	116.00
200.00	Subtotal (see instructions)	117,453,470	0	117,453,470	6,675	117,460,145	200.00
201.00	Less Observation Beds	2,194,974		2,194,974		2,194,974	201.00
202.00	Total (see instructions)	115,258,496	0	115,258,496	6,675	115,265,171	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0032		Period: From 07/01/2017 To 06/30/2018		Worksheet C Part I Date/Time Prepared: 11/26/2018 3:39 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	12,764,655		12,764,655		30.00		
31.00 03100	INTENSIVE CARE UNIT	2,940,995		2,940,995		31.00		
43.00 04300	NURSERY	1,190,941		1,190,941		43.00		
ANCILLARY SERVICE COST CENTERS								
50.00 05000	OPERATING ROOM	13,064,823	39,763,449	52,828,272	0.238895	50.00		
52.00 05200	DELIVERY ROOM & LABOR ROOM	3,166,192	560,128	3,726,320	0.634798	52.00		
53.00 05300	ANESTHESIOLOGY	3,382,862	6,332,386	9,715,248	0.149800	53.00		
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,659,730	17,177,326	19,837,056	0.279562	54.00		
54.01 03630	ULTRA SOUND	406,148	3,285,581	3,691,729	0.136352	54.01		
54.02 03450	NUCLEAR MEDICINE - DIAGNOSTIC	574,414	9,307,591	9,882,005	0.089332	54.02		
54.06 05404	PET SCAN	0	1,222,630	1,222,630	0.142337	54.06		
57.00 05700	CT SCAN	5,829,399	32,004,802	37,834,201	0.030522	57.00		
58.00 05800	MRI	850,768	15,959,147	16,809,915	0.064145	58.00		
59.00 05900	CARDIAC CATHETERIZATION	1,112,949	6,672,643	7,785,592	0.127618	59.00		
60.00 06000	LABORATORY	7,051,841	13,979,796	21,031,637	0.203514	60.00		
62.30 06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0.000000	62.30		
65.00 06500	RESPIRATORY THERAPY	2,169,127	736,616	2,905,743	0.392132	65.00		
66.00 06600	PHYSICAL THERAPY	1,473,429	5,310,284	6,783,713	0.535435	66.00		
67.00 06700	OCCUPATIONAL THERAPY	751,978	2,130,137	2,882,115	0.265840	67.00		
69.00 06900	ELECTROCARDIOLOGY	2,035,895	9,729,597	11,765,492	0.131409	69.00		
70.00 07000	ELECTROENCEPHALOGRAPHY	10,208	2,613,622	2,623,830	0.135202	70.00		
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	14,628,263	18,473,578	33,101,841	0.347710	71.00		
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	13,247,854	5,041,158	18,289,012	0.329510	72.00		
73.00 07300	DRUGS CHARGED TO PATIENTS	18,629,955	18,832,942	37,462,897	0.237404	73.00		
74.00 07400	RENAL DIALYSIS	90,287	3,451	93,738	0.815656	74.00		
76.00 03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0.000000	76.00		
76.01 03650	VASCULAR LAB	252,542	2,996,041	3,248,583	0.161462	76.01		
76.03 03950	WOUND CARE	48,902	5,656,844	5,705,746	0.319343	76.03		
76.97 07697	CARDIAC REHABILITATION	215	705,264	705,479	0.293966	76.97		
OUTPATIENT SERVICE COST CENTERS								
90.00 09000	CLINIC	830	510,570	511,400	0.664040	90.00		
91.00 09100	EMERGENCY	4,009,849	19,610,844	23,620,693	0.219436	91.00		
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)	566,003	2,101,997	2,668,000	0.822704	92.00		
OTHER REIMBURSABLE COST CENTERS								
101.00 10100	HOME HEALTH AGENCY	0	10,557,299	10,557,299		101.00		
SPECIAL PURPOSE COST CENTERS								
113.00 11300	INTEREST EXPENSE					113.00		
116.00 11600	HOSPICE	0	8,063,525	8,063,525		116.00		
200.00	Subtotal (see instructions)	112,911,054	259,339,248	372,250,302		200.00		
201.00	Less Observation Beds					201.00		
202.00	Total (see instructions)	112,911,054	259,339,248	372,250,302		202.00		

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0032	Period: From 07/01/2017 To 06/30/2018	Worksheet C Part I Date/Time Prepared: 11/26/2018 3:39 pm
Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital Cost
		INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
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	03630	ULTRA SOUND	0.000000		54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.000000		54.02
54.06	05404	PET SCAN	0.000000		54.06
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
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000		62.30
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
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	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0.000000		76.00
76.01	03650	VASCULAR LAB	0.000000		76.01
76.03	03950	WOUND CARE	0.000000		76.03
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
116.00	11600	HOSPICE			116.00
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: 14-0032		Period: From 07/01/2017 To 06/30/2018		Worksheet D Part I Date/Time Prepared: 11/26/2018 3:39 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	1,561,568	0	1,561,568	14,719	106.09	30.00
31.00	INTENSIVE CARE UNIT	260,800		260,800	1,716	151.98	31.00
43.00	NURSERY	21,580		21,580	1,410	15.30	43.00
200.00	Total (lines 30 through 199)	1,843,948		1,843,948	17,845		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	7,966	845,113				
31.00	INTENSIVE CARE UNIT	1,105	167,938				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	9,071	1,013,051				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0032	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part II Date/Time Prepared: 11/26/2018 3:39 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)	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	1,825,824	52,828,272	0.034561	6,297,680	217,654	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	167,499	3,726,320	0.044950	62,163	2,794	52.00
53.00	05300 ANESTHESIOLOGY	83,316	9,715,248	0.008576	1,596,051	13,688	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	854,727	19,837,056	0.043087	2,029,189	87,432	54.00
54.01	03630 ULTRA SOUND	64,844	3,691,729	0.017565	304,516	5,349	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	65,380	9,882,005	0.006616	406,430	2,689	54.02
54.06	05404 PET SCAN	4,310	1,222,630	0.003525	0	0	54.06
57.00	05700 CT SCAN	54,542	37,834,201	0.001442	4,506,575	6,498	57.00
58.00	05800 MRI	130,663	16,809,915	0.007773	552,116	4,292	58.00
59.00	05900 CARDIAC CATHETERIZATION	74,389	7,785,592	0.009555	903,854	8,636	59.00
60.00	06000 LABORATORY	350,762	21,031,637	0.016678	4,533,618	75,612	60.00
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	46,510	2,905,743	0.016006	1,545,400	24,736	65.00
66.00	06600 PHYSICAL THERAPY	248,707	6,783,713	0.036662	1,039,531	38,111	66.00
67.00	06700 OCCUPATIONAL THERAPY	19,383	2,882,115	0.006725	526,020	3,537	67.00
69.00	06900 ELECTROCARDIOLOGY	176,637	11,765,492	0.015013	1,581,218	23,739	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	32,024	2,623,830	0.012205	8,234	100	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	289,336	33,101,841	0.008741	7,548,516	65,982	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	149,251	18,289,012	0.008161	6,127,377	50,006	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	522,755	37,462,897	0.013954	11,593,081	161,770	73.00
74.00	07400 RENAL DIALYSIS	9,352	93,738	0.099767	85,433	8,523	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0	0	0.000000	0	0	76.00
76.01	03650 VASCULAR LAB	52,573	3,248,583	0.016183	182,611	2,955	76.01
76.03	03950 WOUND CARE	108,727	5,705,746	0.019056	35,238	671	76.03
76.97	07697 CARDIAC REHABILITATION	17,024	705,479	0.024131	215	5	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	26,561	511,400	0.051938	800	42	90.00
91.00	09100 EMERGENCY	335,729	23,620,693	0.014213	2,754,939	39,156	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	174,628	2,668,000	0.065453	380,505	24,905	92.00
200.00	Total (lines 50 through 199)	5,885,453	336,732,887		54,601,310	868,882	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0032	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part III Date/Time Prepared: 11/26/2018 3:39 pm
Title XVIII		Hospital	PPS

Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
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	14,719	0.00	7,966	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	1,716	0.00	1,105	31.00	
43.00	04300	NURSERY		0	1,410	0.00	0	43.00	
200.00		Total (lines 30 through 199)		0	17,845		9,071	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
43.00	04300	NURSERY	0						43.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0032	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/26/2018 3:39 pm
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Cost Center Description	Title XVIII						Allied Health Post-Stepdown Adjustments	Allied Health Adjustments	
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Hospital		PPS			
	1.00	2A	2.00	3A		3.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	0	0	54.02
54.06	05404	PET SCAN	0	0	0	0	0	0	54.06
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	0	76.00
76.01	03650	VASCULAR LAB	0	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	0	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0032	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/26/2018 3:39 pm
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Cost Center Description		Title XVIII			Hospital	PPS		
		All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	52,828,272	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,726,320	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	9,715,248	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	19,837,056	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	3,691,729	0.000000	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	9,882,005	0.000000	54.02
54.06	05404	PET SCAN	0	0	0	1,222,630	0.000000	54.06
57.00	05700	CT SCAN	0	0	0	37,834,201	0.000000	57.00
58.00	05800	MRI	0	0	0	16,809,915	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	7,785,592	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	21,031,637	0.000000	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,905,743	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,783,713	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,882,115	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	11,765,492	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,623,830	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	33,101,841	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	18,289,012	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	37,462,897	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	93,738	0.000000	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0.000000	76.00
76.01	03650	VASCULAR LAB	0	0	0	3,248,583	0.000000	76.01
76.03	03950	WOUND CARE	0	0	0	5,705,746	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	705,479	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	511,400	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	23,620,693	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	2,668,000	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	336,732,887		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0032	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/26/2018 3:39 pm
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Cost Center Description		Title XVIII				Hospital	
		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)	PPS
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	6,297,680	0	16,735,918	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	62,163	0	98,474	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	1,596,051	0	2,118,984	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	2,029,189	0	3,662,200	0	54.00
54.01	03630 ULTRA SOUND	0.000000	304,516	0	1,179,809	0	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.000000	406,430	0	4,703,427	0	54.02
54.06	05404 PET SCAN	0.000000	0	0	542,325	0	54.06
57.00	05700 CT SCAN	0.000000	4,506,575	0	11,865,427	0	57.00
58.00	05800 MRI	0.000000	552,116	0	6,183,074	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	903,854	0	3,272,855	0	59.00
60.00	06000 LABORATORY	0.000000	4,533,618	0	2,944,650	0	60.00
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000	0	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.000000	1,545,400	0	287,905	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	1,039,531	0	91,289	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	526,020	0	33,827	0	67.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	1,581,218	0	4,836,662	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	8,234	0	1,005,012	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.000000	7,548,516	0	6,008,336	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	6,127,377	0	2,307,330	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	11,593,081	0	8,241,729	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	85,433	0	1,102	0	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0.000000	0	0	0	0	76.00
76.01	03650 VASCULAR LAB	0.000000	182,611	0	1,774,093	0	76.01
76.03	03950 WOUND CARE	0.000000	35,238	0	3,559,291	0	76.03
76.97	07697 CARDIAC REHABILITATION	0.000000	215	0	394,993	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	800	0	57,728	0	90.00
91.00	09100 EMERGENCY	0.000000	2,754,939	0	5,734,847	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0.000000	380,505	0	945,166	0	92.00
200.00	Total (lines 50 through 199)		54,601,310	0	88,586,453	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0032	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part V Date/Time Prepared: 11/26/2018 3:39 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	0.238895	16,735,918	0	0	3,998,127	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.634798	98,474	0	0	62,511	52.00
53.00 05300 ANESTHESIOLOGY	0.149800	2,118,984	0	0	317,424	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.279562	3,662,200	0	0	1,023,812	54.00
54.01 03630 ULTRA SOUND	0.136352	1,179,809	0	0	160,869	54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.089332	4,703,427	0	0	420,167	54.02
54.06 05404 PET SCAN	0.142337	542,325	0	0	77,193	54.06
57.00 05700 CT SCAN	0.030522	11,865,427	0	0	362,157	57.00
58.00 05800 MRI	0.064145	6,183,074	0	0	396,613	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.127618	3,272,855	0	0	417,675	59.00
60.00 06000 LABORATORY	0.203514	2,944,650	1,602	0	599,278	60.00
62.30 06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000	0	0	0	0	62.30
65.00 06500 RESPIRATORY THERAPY	0.392132	287,905	99	0	112,897	65.00
66.00 06600 PHYSICAL THERAPY	0.535435	91,289	0	0	48,879	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.265840	33,827	0	0	8,993	67.00
69.00 06900 ELECTROCARDIOLOGY	0.131409	4,836,662	0	0	635,581	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.135202	1,005,012	0	0	135,880	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0.347710	6,008,336	0	0	2,089,159	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.329510	2,307,330	0	0	760,288	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.237404	8,241,729	335	59,814	1,956,619	73.00
74.00 07400 RENAL DIALYSIS	0.815656	1,102	0	0	899	74.00
76.00 03050 BACTERIOLOGY & MICROBIOLOGY	0.000000	0	0	0	0	76.00
76.01 03650 VASCULAR LAB	0.161462	1,774,093	0	0	286,449	76.01
76.03 03950 WOUND CARE	0.319343	3,559,291	0	0	1,136,635	76.03
76.97 07697 CARDIAC REHABILITATION	0.293966	394,993	0	0	116,115	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.664040	57,728	0	0	38,334	90.00
91.00 09100 EMERGENCY	0.219436	5,734,847	0	132	1,258,432	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0.822704	945,166	0	0	777,592	92.00
200.00 Subtotal (see instructions)		88,586,453	2,036	59,946	17,198,578	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00 Net Charges (line 200 - line 201)		88,586,453	2,036	59,946	17,198,578	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0032	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part V Date/Time Prepared: 11/26/2018 3:39 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	03630	ULTRA SOUND	0	0	54.01
54.02	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	54.02
54.06	05404	PET SCAN	0	0	54.06
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	326	0	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	39	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
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	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	80	14,200	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	76.00
76.01	03650	VASCULAR LAB	0	0	76.01
76.03	03950	WOUND CARE	0	0	76.03
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	29	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	92.00
200.00		Subtotal (see instructions)	445	14,229	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	445	14,229	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0032	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/26/2018 3:39 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		14,719	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		14,719	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)		13,073	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)		7,966	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)		19,628,142	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)		19,628,142	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)		19,628,142	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)		1,333.52	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		10,622,820	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)		10,622,820	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0032	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/26/2018 3:39 pm	
Title XVIII			Hospital		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	3,862,140	1,716	2,250.66	1,105	2,486,979	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)					13,575,054	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					26,684,853	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)					1,013,051	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					868,882	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,881,933	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					24,802,920	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)					1,646	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,333.52	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					2,194,974	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0032		Period: From 07/01/2017 To 06/30/2018		Worksheet D-1 Date/Time Prepared: 11/26/2018 3:39 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	1,561,568	19,628,142	0.079558	2,194,974	174,628	90.00
91.00	Nursing School cost	0	19,628,142	0.000000	2,194,974	0	91.00
92.00	Allied health cost	0	19,628,142	0.000000	2,194,974	0	92.00
93.00	All other Medical Education	0	19,628,142	0.000000	2,194,974	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0032	Period: From 07/01/2017 To 06/30/2018	Worksheet D-3 Date/Time Prepared: 11/26/2018 3:39 pm
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Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		7,252,418		30.00
31.00	03100 INTENSIVE CARE UNIT		1,855,841		31.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.238895	6,297,680	1,504,484	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.634798	62,163	39,461	52.00
53.00	05300 ANESTHESIOLOGY	0.149800	1,596,051	239,088	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.279562	2,029,189	567,284	54.00
54.01	03630 ULTRA SOUND	0.136352	304,516	41,521	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.089332	406,430	36,307	54.02
54.06	05404 PET SCAN	0.142337	0	0	54.06
57.00	05700 CT SCAN	0.030522	4,506,575	137,550	57.00
58.00	05800 MRI	0.064145	552,116	35,415	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.127618	903,854	115,348	59.00
60.00	06000 LABORATORY	0.203514	4,533,618	922,655	60.00
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.392132	1,545,400	606,001	65.00
66.00	06600 PHYSICAL THERAPY	0.535435	1,039,531	556,601	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.265840	526,020	139,837	67.00
69.00	06900 ELECTROCARDIOLOGY	0.131409	1,581,218	207,786	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.135202	8,234	1,113	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.347710	7,548,516	2,624,694	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.329510	6,127,377	2,019,032	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.237404	11,593,081	2,752,244	73.00
74.00	07400 RENAL DIALYSIS	0.815656	85,433	69,684	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0.000000	0	0	76.00
76.01	03650 VASCULAR LAB	0.161462	182,611	29,485	76.01
76.03	03950 WOUND CARE	0.320513	35,238	11,294	76.03
76.97	07697 CARDIAC REHABILITATION	0.293966	215	63	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.664040	800	531	90.00
91.00	09100 EMERGENCY	0.219436	2,754,939	604,533	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0.822704	380,505	313,043	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		54,601,310	13,575,054	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)		54,601,310		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0032	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 11/26/2018 3: 39 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)		4,537,795	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		13,613,386	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)		195,266	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		128.33	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 which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.09	30.00
31.00	Percentage of Medicaid patient days (see instructions)		15.26	31.00
32.00	Sum of lines 30 and 31		19.35	32.00
33.00	Allowable disproportionate share percentage (see instructions)		5.33	33.00
34.00	Disproportionate share adjustment (see instructions)		241,864	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0032	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 11/26/2018 3:39 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)	5,977,483,147	6,766,695,164	35.00	
35.01	Factor 3 (see instructions)	0.000093481	0.000097025	35.01	
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	558,782	656,540	35.02	
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	140,844	491,056	35.03	
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	631,900		36.00	
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00	
		Before 1/1	On/After 1/1		
		1.00	1.01		
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0	0	41.00	
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0	0	41.01	
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00	
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 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	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)	19,220,211		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)		19,220,211	49.00	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,493,152	50.00	
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00	
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00	
53.00	Nursing and Allied Health Managed Care payment		0	53.00	
54.00	Special add-on payments for new technologies		0	54.00	
54.01	Islet isolation add-on payment		0	54.01	
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00	
56.00	Cost of physicians' services in a teaching hospital (see 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)		20,713,363	59.00	
60.00	Primary payer payments		2,153	60.00	
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		20,711,210	61.00	
62.00	Deductibles billed to program beneficiaries		2,338,884	62.00	
63.00	Coinsurance billed to program beneficiaries		20,704	63.00	
64.00	Allowable bad debts (see instructions)		158,821	64.00	
65.00	Adjusted reimbursable bad debts (see instructions)		103,234	65.00	
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		61,120	66.00	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		18,454,856	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)		60,312	70.93	
70.94	HRR adjustment amount (see instructions)		-17,671	70.94	
70.95	Recovery of accelerated depreciation		0	70.95	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0032	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 11/26/2018 3:39 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		18,497,497	71.00
71.01	Sequestration adjustment (see instructions)		369,950	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		18,190,495	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)		-62,948	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		167,559	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
			Prior to 10/1	On/After 10/1
			1.00	2.00
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0032

Period:
From 07/01/2017
To 06/30/2018

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/26/2018 3:39 pm

		Title XVIII			Hospital		PPS	
	W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)		
	0	1.00	2.00	3.00	4.00	5.00		
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,537,795	0	4,537,795		4,537,795	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	13,613,386	0		18,151,182	18,151,182	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	195,266	0	0	195,266	195,266	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0533	0.0533	0.0533	0.0533		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	241,864	0	60,466	181,398	241,864	11.00
11.01	Uncompensated care payments	36.00	631,900	0	140,844	491,055	631,899	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	19,220,211	0	4,739,105	14,481,106	19,220,211	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	19,220,211	0	4,739,105	14,481,106	19,220,211	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,493,152	0	0	1,493,152	1,493,152	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ acquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0032

Period:
From 07/01/2017
To 06/30/2018

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/26/2018 3:39 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	4,739,105	15,974,258	20,713,363	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,464,959	0	0	1,464,959	1,464,959	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	28,193	0	0	28,193	28,193	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	0.0000	22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	0.0000	24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,493,152	0	0	1,493,152	1,493,152	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 14-0032		Period: From 07/01/2017 To 06/30/2018		Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/26/2018 3:39 pm	
		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,537,795	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	13,613,386		18,151,182	18,151,182	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	195,266	0	195,266	195,266	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0533	0.0533	0.0533		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	241,864	0	241,864	241,864	11.00
11.01	Uncompensated care payments	36.00	631,900	140,844	491,056	631,900	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	19,220,211	140,844	19,079,367	19,220,211	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	19,220,211	140,844	19,079,367	19,220,211	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,493,152	0	1,493,152	1,493,152	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			140,844	20,572,519	20,713,363	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 14-0032	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/26/2018 3:39 pm
		Title XVIII	Hospital	PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,464,959	0	1,464,959	1,464,959	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	28,193	0	28,193	28,193	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,493,152	0	1,493,152	1,493,152	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	60,312	0	60,312	60,312	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-17,671	0	-17,671	-17,671	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0032	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/26/2018 3:39 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		14,674	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		17,198,578	2.00
3.00	OPPS payments		15,853,336	3.00
4.00	Outlier payment (see instructions)		49,240	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)		14,674	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		61,982	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)		61,982	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		61,982	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		47,308	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)		14,674	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)		15,902,576	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		3,208,851	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)		12,708,399	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		12,708,399	30.00
31.00	Primary payer payments		1,114	31.00
32.00	Subtotal (line 30 minus line 31)		12,707,285	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)		127,343	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		82,773	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		33,419	36.00
37.00	Subtotal (see instructions)		12,790,058	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-341	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)		12,790,399	40.00
40.01	Sequestration adjustment (see instructions)		255,808	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		12,625,780	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-91,189	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: 14-0032		Period: From 07/01/2017 To 06/30/2018		Worksheet E-1 Part I Date/Time Prepared: 11/26/2018 3:39 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		18,268,043		12,754,264	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	02/01/2018	77,548	02/01/2018	128,484		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)		-77,548		-128,484		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)		18,190,495		12,625,780		4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0		5.50
5.51			0		0		5.51
5.52			0		0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		0		6.01
6.02	SETTLEMENT TO PROGRAM		62,948		91,189		6.02
7.00	Total Medicare program liability (see instructions)		18,127,547		12,534,591		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: 14-0032	Period: From 07/01/2017 To 06/30/2018	Worksheet E-1 Part II Date/Time Prepared: 11/26/2018 3:39 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 IPSS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

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

Provider CCN: 14-0032

Period:
From 07/01/2017
To 06/30/2018

Worksheet G
Date/Time Prepared:
11/26/2018 3:39 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	12,174,561	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	22,378,820	0	0	0	4.00
5.00	Other receivable	704,401	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	4,681,871	0	0	0	7.00
8.00	Prepaid expenses	265,090	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	520,391	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	40,725,134	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,699,574	0	0	0	12.00
13.00	Land improvements	3,360,444	0	0	0	13.00
14.00	Accumulated depreciation	-2,288,948	0	0	0	14.00
15.00	Buildings	70,039,702	0	0	0	15.00
16.00	Accumulated depreciation	-33,519,436	0	0	0	16.00
17.00	Leasehold improvements	326,265	0	0	0	17.00
18.00	Accumulated depreciation	-75,501	0	0	0	18.00
19.00	Fixed equipment	15,074,960	0	0	0	19.00
20.00	Accumulated depreciation	-14,212,455	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	81,346,646	0	0	0	23.00
24.00	Accumulated depreciation	-67,479,142	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	9,484,130	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	64,756,239	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	345,169,830	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	7,594,342	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	352,764,172	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	458,245,545	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	4,223,380	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,321,166	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	757,600	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	1,766,149	0	0	0	43.00
44.00	Other current liabilities	17,367,610	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	28,435,905	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	2,043,441	0	0	0	46.00
47.00	Notes payable	10,721,038	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	12,350,668	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	25,115,147	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	53,551,052	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	404,694,493				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)	404,694,493	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	458,245,545	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0032

Period:
From 07/01/2017
To 06/30/2018

Worksheet G-1

Date/Time Prepared:
11/26/2018 3:39 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		378,666,584		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		29,812,465				2.00
3.00	Total (sum of line 1 and line 2)		408,479,049		0		3.00
4.00	CHANGE IN NET ASSETS	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		408,479,049		0		11.00
12.00	CHANGE IN NET ASSETS	3,784,556		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		3,784,556		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		404,694,493		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	CHANGE IN NET ASSETS		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	CHANGE IN NET 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: 14-0032

Period:
From 07/01/2017
To 06/30/2018

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/26/2018 3:39 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	14,389,189		14,389,189	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	14,389,189		14,389,189	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,015,344		3,015,344	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)	3,015,344		3,015,344	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	17,404,533		17,404,533	17.00
18.00	Ancillary services	93,418,343	229,368,324	322,786,667	18.00
19.00	Outpatient services	4,047,917	20,423,982	24,471,899	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		10,557,299	10,557,299	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	141,658	7,921,867	8,063,525	26.00
27.00	PROFESSIONAL FEES	0	2,701,048	2,701,048	27.00
27.01	OTHER NONREIMBURSABLE COST CENTERS	0	4,281,866	4,281,866	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	115,012,451	275,254,386	390,266,837	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		124,797,121		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)		124,797,121		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-0032	Period: From 07/01/2017 To 06/30/2018	Worksheet G-3 Date/Time Prepared: 11/26/2018 3:39 pm
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		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	390,266,837	1.00
2.00	Less contractual allowances and discounts on patients' accounts	252,063,684	2.00
3.00	Net patient revenues (line 1 minus line 2)	138,203,153	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	124,797,121	4.00
5.00	Net income from service to patients (line 3 minus line 4)	13,406,032	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	13,511,000	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	3,687,433	24.00
24.01	NON OPERATING REVENUE	2,627,000	24.01
25.00	Total other income (sum of lines 6-24)	19,825,433	25.00
26.00	Total (line 5 plus line 25)	33,231,465	26.00
27.00	OTHER CHANGES IN ASSETS	3,419,000	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	3,419,000	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	29,812,465	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0032

Period: From 07/01/2017

Worksheet H

HHA CCN: 14-7661

To 06/30/2018

Date/Time Prepared: 11/26/2018 3:39 pm

Home Health Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures		0		0	0	1.00
2.00	Capital Related - Movable Equipment		0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	262,269	262,269	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	607,786	0	17,389	0	625,303	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	4,051,041	0	115,810	0	4,166,851	6.00
7.00	Physical Therapy	1,117,436	0	31,942	125,478	1,274,856	7.00
8.00	Occupational Therapy	370,571	0	10,585	0	381,156	8.00
9.00	Speech Pathology	98,234	0	2,799	0	101,033	9.00
10.00	Medical Social Services	102,229	0	2,929	0	105,158	10.00
11.00	Home Health Aide	137,153	0	3,930	0	141,083	11.00
12.00	Supplies (see instructions)	0	0	0	350,323	350,323	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Tel emedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	6,484,450	0	185,384	125,478	1,237,895	24.00
	Reclassification	Reclassified Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0		1.00
2.00	Capital Related - Movable Equipment	0	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	262,269	0	262,269		3.00
4.00	Transportation	0	0	0	0		4.00
5.00	Administrative and General	-2,484	1,247,994	-3,739	1,244,255		5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	4,166,851	0	4,166,851		6.00
7.00	Physical Therapy	0	1,274,856	0	1,274,856		7.00
8.00	Occupational Therapy	0	381,156	0	381,156		8.00
9.00	Speech Pathology	0	101,033	0	101,033		9.00
10.00	Medical Social Services	0	105,158	0	105,158		10.00
11.00	Home Health Aide	0	141,083	0	141,083		11.00
12.00	Supplies (see instructions)	-350,323	0	0	0		12.00
13.00	Drugs	0	0	0	0		13.00
14.00	DME	0	0	0	0		14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0	0		17.00
18.00	Clinic	0	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0	0		19.00
20.00	Day Care Program	0	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0	0		21.00
22.00	Homemaker Service	0	0	0	0		22.00
23.00	All Others (specify)	0	0	0	0		23.00
23.50	Tel emedicine	0	0	0	0		23.50
24.00	Total (sum of lines 1-23)	-352,807	7,680,400	-3,739	7,676,661		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: 14-0032 HHA CCN: 14-7661		Period: From 07/01/2017 To 06/30/2018		Worksheet H-1 Part I Date/Time Prepared: 11/26/2018 3:39 pm 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				
	0	1.00	2.00	3.00	4.00	4A.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	262,269	0	0	262,269	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	1,244,255	0	0	262,269	0	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	4,166,851	0	0	0	0	6.00
7.00	Physical Therapy	1,274,856	0	0	0	0	7.00
8.00	Occupational Therapy	381,156	0	0	0	0	8.00
9.00	Speech Pathology	101,033	0	0	0	0	9.00
10.00	Medical Social Services	105,158	0	0	0	0	10.00
11.00	Home Health Aide	141,083	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Tel emedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	7,676,661	0	0	262,269	0	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	1,506,524					5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	1,017,393	5,184,244				6.00
7.00	Physical Therapy	311,274	1,586,130				7.00
8.00	Occupational Therapy	93,065	474,221				8.00
9.00	Speech Pathology	24,669	125,702				9.00
10.00	Medical Social Services	25,676	130,834				10.00
11.00	Home Health Aide	34,447	175,530				11.00
12.00	Supplies (see instructions)	0	0				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	Tel emedicine	0	0				23.50
24.00	Total (sum of lines 1-23)		7,676,661				24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-0032
HHA CCN: 14-7661

Period:
From 07/01/2017
To 06/30/2018

Worksheet H-1
Part II
Date/Time Prepared:
11/26/2018 3:39 pm
PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	3,990			0		1.00
2.00	Capital Related - Movable Equipment		133,958		0		2.00
3.00	Plant Operation & Maintenance	0	0	3,990	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	3,990	133,958	3,990	0	-1,506,524	6,170,137
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	4,166,851
7.00	Physical Therapy	0	0	0	0	0	1,274,856
8.00	Occupational Therapy	0	0	0	0	0	381,156
9.00	Speech Pathology	0	0	0	0	0	101,033
10.00	Medical Social Services	0	0	0	0	0	105,158
11.00	Home Health Aide	0	0	0	0	0	141,083
12.00	Supplies (see instructions)	0	0	0	0	0	0
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)	3,990	133,958	3,990	0	-1,506,524	6,170,137
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	262,269	0	0	1,506,524
26.00	Unit Cost Multiplier	0.000000	0.000000	65.731579	0.000000	0	0.244164

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0032

Period: From 07/01/2017

Worksheet H-2

HHA CCN: 14-7661

To 06/30/2018

Part I
Date/Time Prepared:
11/26/2018 3:39 pm

Home Health Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		BLDG & FIXT	MVBLE EQUIP				
		0	1.00				
1.00 Administrative and General	0	35,448	80,474	200,233	316,155	112,592	1.00
2.00 Skilled Nursing Care	5,184,244	0	0	1,334,602	6,518,846	2,321,552	2.00
3.00 Physical Therapy	1,586,130	0	0	368,136	1,954,266	695,971	3.00
4.00 Occupational Therapy	474,221	0	0	122,084	596,305	212,362	4.00
5.00 Speech Pathology	125,702	0	0	32,363	158,065	56,292	5.00
6.00 Medical Social Services	130,834	0	0	33,679	164,513	58,588	6.00
7.00 Home Health Aide	175,530	0	0	45,185	220,715	78,603	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19) (2)	7,676,661	35,448	80,474	2,136,282	9,928,865	3,535,960	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00
Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
	6.00	7.00	8.00	9.00	10.00	11.00	
1.00 Administrative and General	303	175,768	0	42,576	0	231,711	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19) (2)	303	175,768	0	42,576	0	231,711	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: 14-0032

Period: From 07/01/2017

Worksheet H-2

HHA CCN: 14-7661

To 06/30/2018

Part I
Date/Time Prepared:
11/26/2018 3:39 pm

Home Health Agency I

PPS

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
		13.00	14.00	15.00	16.00	17.00	24.00	
1.00	Administrative and General	482,215	5,419	157,053	0	0	1,523,792	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	8,840,398	2.00
3.00	Physical Therapy	0	0	0	0	0	2,650,237	3.00
4.00	Occupational Therapy	0	0	0	0	0	808,667	4.00
5.00	Speech Pathology	0	0	0	0	0	214,357	5.00
6.00	Medical Social Services	0	0	0	0	0	223,101	6.00
7.00	Home Health Aide	0	0	0	0	0	299,318	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	Telmedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	482,215	5,419	157,053	0	0	14,559,870	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		25.00	26.00	27.00	28.00			
1.00	Administrative and General	0	1,523,792					1.00
2.00	Skilled Nursing Care	0	8,840,398	1,033,360	9,873,758			2.00
3.00	Physical Therapy	0	2,650,237	309,786	2,960,023			3.00
4.00	Occupational Therapy	0	808,667	94,525	903,192			4.00
5.00	Speech Pathology	0	214,357	25,056	239,413			5.00
6.00	Medical Social Services	0	223,101	26,078	249,179			6.00
7.00	Home Health Aide	0	299,318	34,987	334,305			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	Telmedicine	0	0	0	0			19.50
20.00	Total (sum of lines 1-19) (2)	0	14,559,870	1,523,792	14,559,870			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.			0.116890				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: 14-0032 HHA CCN: 14-7661	Period: From 07/01/2017 To 06/30/2018	Worksheet H-2 Part II Date/Time Prepared: 11/26/2018 3:39 pm PPS
			Home Health Agency I	

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation 5A	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (MAINT. HOURS)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00					
1.00 Administrative and General	4,902	133,958	607,785	0	316,155	241	1.00
2.00 Skilled Nursing Care	0	0	4,051,041	0	6,518,846	0	2.00
3.00 Physical Therapy	0	0	1,117,436	0	1,954,266	0	3.00
4.00 Occupational Therapy	0	0	370,571	0	596,305	0	4.00
5.00 Speech Pathology	0	0	98,234	0	158,065	0	5.00
6.00 Medical Social Services	0	0	102,229	0	164,513	0	6.00
7.00 Home Health Aide	0	0	137,153	0	220,715	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)	4,902	133,958	6,484,449		9,928,865	241	20.00
21.00 Total cost to be allocated	35,448	80,474	2,136,282		3,535,960	303	21.00
22.00 Unit cost multiplier	7.231334	0.600741	0.329447		0.356129	1.257261	22.00
Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATIVE (DIRECT NRSING HRS)	
	7.00	8.00	9.00	10.00	11.00	13.00	
1.00 Administrative and General	4,902	0	693	0	12,315	256,143	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	4,902	0	693	0	12,315	256,143	20.00
21.00 Total cost to be allocated	175,768	0	42,576	0	231,711	482,215	21.00
22.00 Unit cost multiplier	35.856385	0.000000	61.437229	0.000000	18.815347	1.882601	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 14-0032	Period: From 07/01/2017	Worksheet H-2 Part II Date/Time Prepared: 11/26/2018 3:39 pm
	HHA CCN: 14-7661	To 06/30/2018	
		Home Health Agency I	PPS

Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)		
	14.00	15.00	16.00	17.00		
1.00 Administrative and General	386,046	212,307	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)	386,046	212,307	0	0		20.00
21.00 Total cost to be allocated	5,419	157,053	0	0		21.00
22.00 Unit cost multiplier	0.014037	0.739745	0.000000	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 14-0032 HHA CCN: 14-7661		Period: From 07/01/2017 To 06/30/2018		Worksheet H-3 Part I Date/Time Prepared: 11/26/2018 3:39 pm	
				Title XVIII		Home Health Agency I		PPS	
Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (col. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)		
		0	1.00	2.00	3.00	4.00	5.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care	2.00	9,873,758		9,873,758	40,929	241.24		1.00
2.00	Physical Therapy	3.00	2,960,023	0	2,960,023	16,188	182.85		2.00
3.00	Occupational Therapy	4.00	903,192	0	903,192	4,843	186.49		3.00
4.00	Speech Pathology	5.00	239,413	0	239,413	1,369	174.88		4.00
5.00	Medical Social Services	6.00	249,179		249,179	470	530.17		5.00
6.00	Home Health Aide	7.00	334,305		334,305	5,060	66.07		6.00
7.00	Total (sum of lines 1-6)		14,559,870	0	14,559,870	68,859			7.00
Program Visits									
Cost Center Description		Cost Limits	CBSA No. (1)	Part A	Part B				
					Not Subject to Deductibles & Insurance	Subject to Deductibles			
		0	1.00	2.00	3.00	4.00	5.00		
Limitation Cost Computation									
8.00	Skilled Nursing Care		41180	0	7,470		8.00		
8.01	Skilled Nursing Care		99914	0	11,552		8.01		
8.02	Skilled Nursing Care		16060	0	2		8.02		
8.03	Skilled Nursing Care		44180	0	0		8.03		
9.00	Physical Therapy		41180	0	3,736		9.00		
9.01	Physical Therapy		99914	0	4,630		9.01		
9.02	Physical Therapy		16060	0	7		9.02		
9.03	Physical Therapy		44180	0	0		9.03		
10.00	Occupational Therapy		41180	0	1,320		10.00		
10.01	Occupational Therapy		99914	0	1,070		10.01		
10.02	Occupational Therapy		16060	0	0		10.02		
10.03	Occupational Therapy		44180	0	0		10.03		
11.00	Speech Pathology		41180	0	357		11.00		
11.01	Speech Pathology		99914	0	174		11.01		
11.02	Speech Pathology		16060	0	0		11.02		
11.03	Speech Pathology		44180	0	0		11.03		
12.00	Medical Social Services		41180	0	85		12.00		
12.01	Medical Social Services		99914	0	122		12.01		
12.02	Medical Social Services		16060	0	0		12.02		
12.03	Medical Social Services		44180	0	0		12.03		
13.00	Home Health Aide		41180	0	874		13.00		
13.01	Home Health Aide		99914	0	2,333		13.01		
13.02	Home Health Aide		16060	0	0		13.02		
13.03	Home Health Aide		44180	0	0		13.03		
14.00	Total (sum of lines 8-13)			0	33,732		14.00		
Cost Center Description		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (col. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)		
		0	1.00	2.00	3.00	4.00	5.00		
Supplies and Drugs Cost Computations									
15.00	Cost of Medical Supplies	8.00	0	0	0	248,351	0.000000		
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000		

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 14-0032 HHA CCN: 14-7661		Period: From 07/01/2017 To 06/30/2018		Worksheet H-3 Part I Date/Time Prepared: 11/26/2018 3:39 pm	
				Title XVIII		Home Health Agency I		PPS	
Cost Center Description	Program Visits			Cost of Services Part A	Part B				
	Part A	Part B			Part A	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	19,024	0	4,589,350			1.00	
2.00	Physical Therapy	0	8,373	0	1,531,003			2.00	
3.00	Occupational Therapy	0	2,390	0	445,711			3.00	
4.00	Speech Pathology	0	531	0	92,861			4.00	
5.00	Medical Social Services	0	207	0	109,745			5.00	
6.00	Home Health Aide	0	3,207	0	211,886			6.00	
7.00	Total (sum of lines 1-6)	0	33,732	0	6,980,556			7.00	
Cost Center Description									
		6.00	7.00	8.00	9.00	10.00	11.00		
Limitation Cost Computation									
8.00	Skilled Nursing Care							8.00	
8.01	Skilled Nursing Care							8.01	
8.02	Skilled Nursing Care							8.02	
8.03	Skilled Nursing Care							8.03	
9.00	Physical Therapy							9.00	
9.01	Physical Therapy							9.01	
9.02	Physical Therapy							9.02	
9.03	Physical Therapy							9.03	
10.00	Occupational Therapy							10.00	
10.01	Occupational Therapy							10.01	
10.02	Occupational Therapy							10.02	
10.03	Occupational Therapy							10.03	
11.00	Speech Pathology							11.00	
11.01	Speech Pathology							11.01	
11.02	Speech Pathology							11.02	
11.03	Speech Pathology							11.03	
12.00	Medical Social Services							12.00	
12.01	Medical Social Services							12.01	
12.02	Medical Social Services							12.02	
12.03	Medical Social Services							12.03	
13.00	Home Health Aide							13.00	
13.01	Home Health Aide							13.01	
13.02	Home Health Aide							13.02	
13.03	Home Health Aide							13.03	
14.00	Total (sum of lines 8-13)							14.00	
Program Covered Charges									
Cost Center Description	Part A	Part B		Part A	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
Supplies and Drugs Cost Computations									
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00	
16.00	Cost of Drugs	0	0	0	0	0	0	16.00	

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 14-0032 HHA CCN: 14-7661	Period: From 07/01/2017 To 06/30/2018	Worksheet H-3 Part I Date/Time Prepared: 11/26/2018 3:39 pm
		Title XVIII	Home Health Agency I	PPS

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	4,589,350	1.00
2.00	Physical Therapy	1,531,003	2.00
3.00	Occupational Therapy	445,711	3.00
4.00	Speech Pathology	92,861	4.00
5.00	Medical Social Services	109,745	5.00
6.00	Home Health Aide	211,886	6.00
7.00	Total (sum of lines 1-6)	6,980,556	7.00
Cost Center Description		12.00	
Limitation Cost Computation			
8.00	Skilled Nursing Care		8.00
8.01	Skilled Nursing Care		8.01
8.02	Skilled Nursing Care		8.02
8.03	Skilled Nursing Care		8.03
9.00	Physical Therapy		9.00
9.01	Physical Therapy		9.01
9.02	Physical Therapy		9.02
9.03	Physical Therapy		9.03
10.00	Occupational Therapy		10.00
10.01	Occupational Therapy		10.01
10.02	Occupational Therapy		10.02
10.03	Occupational Therapy		10.03
11.00	Speech Pathology		11.00
11.01	Speech Pathology		11.01
11.02	Speech Pathology		11.02
11.03	Speech Pathology		11.03
12.00	Medical Social Services		12.00
12.01	Medical Social Services		12.01
12.02	Medical Social Services		12.02
12.03	Medical Social Services		12.03
13.00	Home Health Aide		13.00
13.01	Home Health Aide		13.01
13.02	Home Health Aide		13.02
13.03	Home Health Aide		13.03
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 14-0032 HHA CCN: 14-7661	Period: From 07/01/2017 To 06/30/2018	Worksheet H-3 Part II Date/Time Prepared: 11/26/2018 3:39 pm PPS
		Title XVIII	Home Health Agency I	

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	0.535435	0	0	col. 2, line 2.00 1.00
2.00	Occupational Therapy	67.00	0.265840	0	0	col. 2, line 3.00 2.00
3.00	Speech Pathology					3.00
4.00	Cost of Medical Supplies	71.00	0.347710	0	0	col. 2, line 15.00 4.00
5.00	Cost of Drugs	73.00	0.237404	0	0	col. 2, line 16.00 5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0032 HHA CCN: 14-7661	Period: From 07/01/2017 To 06/30/2018	Worksheet H-4 Part I-II Date/Time Prepared: 11/26/2018 3:39 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	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	4,352,908	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	653,486	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	85,027	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	72,477	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	199,095	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	11,423	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)	0	0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	5,374,416	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	5,374,416	24.00
25.00	Coinsurance billed to program patients (from your records)	0	0	25.00
26.00	Net cost (line 24 minus line 25)	0	5,374,416	26.00
27.00	Reimbursable bad debts (from your records)	0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	5,374,416	29.00
30.00	OTHER PSR ADJUSTMENT	0	-4,985	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	5,369,431	31.00
31.01	Sequestration adjustment (see instructions)	0	107,388	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	5,262,043	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0032	Period: From 07/01/2017 To 06/30/2018	Worksheet H-5
	HHA CCN: 14-7661	Home Health Agency I	Date/Time Prepared: 11/26/2018 3:39 pm 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		5,262,043	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		5,262,043	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		5,262,043	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
				0	1.00	2.00
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0032

Period: From 07/01/2017

Worksheet 0

Hospice CCN: 14-1658

To 06/30/2018

Date/Time Prepared: 11/26/2018 3:39 pm

		Hospice I				
		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI- CATIONS	SUBTOTAL
		1.00	2.00	3.00	4.00	5.00
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0
2.00	CAP REL COSTS-MVBLE EQUIP*		91,487	91,487	0	91,487
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0
4.00	ADMINISTRATIVE & GENERAL*	212,097	76,757	288,854	-245,547	43,307
5.00	PLANT OPERATION & MAINTENANCE*	0	8,489	8,489	0	8,489
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0
7.00	HOUSEKEEPING*	0	0	0	0	0
8.00	DIETARY*	0	0	0	0	0
9.00	NURSING ADMINISTRATION*	0	0	0	0	0
10.00	ROUTINE MEDICAL SUPPLIES*	0	1,337	1,337	0	1,337
11.00	MEDICAL RECORDS*	0	0	0	0	0
12.00	STAFF TRANSPORTATION*	0	0	0	0	0
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0
14.00	PHARMACY*	0	207,116	207,116	0	207,116
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0
17.00	PATIENT/RESIDENTIAL CARE SERVICES					
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		518,265	518,265	0	518,265
26.00	PHYSICIAN SERVICES**	0	52,246	52,246	0	52,246
27.00	NURSE PRACTITIONER**	12,679	15	12,694	0	12,694
28.00	REGISTERED NURSE**	759,879	924	760,803	0	760,803
29.00	LPN/LVN**	0	0	0	0	0
30.00	PHYSICAL THERAPY**	0	0	0	0	0
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0
33.00	MEDICAL SOCIAL SERVICES**	76,167	92	76,259	0	76,259
34.00	SPIRITUAL COUNSELING**	35,428	43	35,471	0	35,471
35.00	DIETARY COUNSELING**	0	0	0	0	0
36.00	COUNSELING - OTHER**	0	0	0	0	0
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	72,875	88	72,963	0	72,963
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	75,200	75,200	0	75,200
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0
40.00	IMAGING SERVICES**	0	0	0	0	0
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	37,093	37,093	0	37,093
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0
43.00	OUTPATIENT SERVICES**	0	0	0	0	0
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	496	3	499	0	499
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0
62.00	FUNDRAISING*	0	0	0	0	0
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0
66.00	RESIDENTIAL CARE*	0	0	0	0	0
67.00	ADVERTISING*	0	0	0	0	0
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0
69.00	THRIFT STORE*	0	0	0	0	0
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0
100.00	TOTAL	1,169,621	1,069,155	2,238,776	-245,547	1,993,229

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0032

Period: From 07/01/2017

Worksheet 0

Hospice CCN: 14-1658

To 06/30/2018

Date/Time Prepared: 11/26/2018 3:39 pm

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	Hospice I
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	91,487	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	43,307	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	8,489	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	6.00
7.00	HOUSEKEEPING*	0	0	7.00
8.00	DIETARY*	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	1,337	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	13.00
14.00	PHARMACY*	0	207,116	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			17.00
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	518,265	25.00
26.00	PHYSICIAN SERVICES**	0	52,246	26.00
27.00	NURSE PRACTITIONER**	0	12,694	27.00
28.00	REGISTERED NURSE**	0	760,803	28.00
29.00	LPN/LVN**	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	76,259	33.00
34.00	SPIRITUAL COUNSELING**	0	35,471	34.00
35.00	DIETARY COUNSELING**	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	0	72,963	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	75,200	38.00
39.00	PATIENT TRANSPORTATION**	0	0	39.00
40.00	IMAGING SERVICES**	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	37,093	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	499	46.00
NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	61.00
62.00	FUNDRAISING*	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	66.00
67.00	ADVERTISING*	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	68.00
69.00	THRIFT STORE*	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	71.00
100.00	TOTAL	0	1,993,229	100.00

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE	Provider CCN: 14-0032 Hospice CCN: 14-1658	Period: From 07/01/2017 To 06/30/2018	Worksheet 0-2 Date/Time Prepared: 11/26/2018 3:39 pm
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	Hospice I					
	SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
	1.00	2.00	3.00	4.00	5.00	
DI RECT PATIENT CARE SERVICE COST CENTERS						
25.00						25.00
26.00						26.00
27.00						27.00
28.00						28.00
29.00						29.00
30.00						30.00
31.00						31.00
32.00						32.00
33.00						33.00
34.00						34.00
35.00						35.00
36.00						36.00
37.00						37.00
38.00						38.00
39.00						39.00
40.00						40.00
41.00						41.00
42.00						42.00
42.50						42.50
43.00						43.00
44.00						44.00
45.00						45.00
46.00						46.00
100.00						100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

	ADJUSTMENTS		TOTAL (col. 5 ± col. 6)		
	6.00		7.00		
DI RECT PATIENT CARE SERVICE COST CENTERS					
25.00					25.00
26.00					26.00
27.00					27.00
28.00					28.00
29.00					29.00
30.00					30.00
31.00					31.00
32.00					32.00
33.00					33.00
34.00					34.00
35.00					35.00
36.00					36.00
37.00					37.00
38.00					38.00
39.00					39.00
40.00					40.00
41.00					41.00
42.00					42.00
42.50					42.50
43.00					43.00
44.00					44.00
45.00					45.00
46.00					46.00
100.00					100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT RESPIRE CARE	Provider CCN: 14-0032 Hospice CCN: 14-1658	Period: From 07/01/2017 To 06/30/2018	Worksheet 0-3 Date/Time Prepared: 11/26/2018 3:39 pm
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	Hospice I					
	SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
	1.00	2.00	3.00	4.00	5.00	
DI RECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		50,605	50,605	0	50,605 25.00
26.00	PHYSICIAN SERVICES	0	92	92	0	92 26.00
27.00	NURSE PRACTITIONER	25	0	25	0	25 27.00
28.00	REGISTERED NURSE	1,473	2	1,475	0	1,475 28.00
29.00	LPN/LVN	0	0	0	0	0 29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0 30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0 31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0 32.00
33.00	MEDICAL SOCIAL SERVICES	148	0	148	0	148 33.00
34.00	SPIRITUAL COUNSELING	69	0	69	0	69 34.00
35.00	DIETARY COUNSELING	0	0	0	0	0 35.00
36.00	COUNSELING - OTHER	0	0	0	0	0 36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	141	0	141	0	141 37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0 38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0 39.00
40.00	IMAGING SERVICES	0	0	0	0	0 40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0 41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	65	65	0	65 42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0 43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0 44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0 45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	1	0	1	0	1 46.00
100.00	TOTAL *	1,857	50,764	52,621	0	52,621 100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

	ADJUSTMENTS	TOTAL (col. 5	
	6.00	± col. 6) 7.00	
DI RECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	50,605 25.00
26.00	PHYSICIAN SERVICES	0	92 26.00
27.00	NURSE PRACTITIONER	0	25 27.00
28.00	REGISTERED NURSE	0	1,475 28.00
29.00	LPN/LVN	0	0 29.00
30.00	PHYSICAL THERAPY	0	0 30.00
31.00	OCCUPATIONAL THERAPY	0	0 31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0 32.00
33.00	MEDICAL SOCIAL SERVICES	0	148 33.00
34.00	SPIRITUAL COUNSELING	0	69 34.00
35.00	DIETARY COUNSELING	0	0 35.00
36.00	COUNSELING - OTHER	0	0 36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	141 37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0 38.00
39.00	PATIENT TRANSPORTATION	0	0 39.00
40.00	IMAGING SERVICES	0	0 40.00
41.00	LABS & DIAGNOSTICS	0	0 41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	65 42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0 42.50
43.00	OUTPATIENT SERVICES	0	0 43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0 44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0 45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	1 46.00
100.00	TOTAL *	0	52,621 100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL INPATIENT CARE	Provider CCN: 14-0032 Hospice CCN: 14-1658	Period: From 07/01/2017 To 06/30/2018	Worksheet 0-4 Date/Time Prepared: 11/26/2018 3:39 pm
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	Hospice I					
	SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
	1.00	2.00	3.00	4.00	5.00	
DI RECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		467,660	467,660	0	467,660 25.00
26.00	PHYSICIAN SERVICES	0	851	851	0	851 26.00
27.00	NURSE PRACTITIONER	201	0	201	0	201 27.00
28.00	REGISTERED NURSE	12,063	15	12,078	0	12,078 28.00
29.00	LPN/LVN	0	0	0	0	0 29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0 30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0 31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0 32.00
33.00	MEDICAL SOCIAL SERVICES	1,209	1	1,210	0	1,210 33.00
34.00	SPIRITUAL COUNSELING	562	1	563	0	563 34.00
35.00	DIETARY COUNSELING	0	0	0	0	0 35.00
36.00	COUNSELING - OTHER	0	0	0	0	0 36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	1,157	1	1,158	0	1,158 37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0 38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0 39.00
40.00	IMAGING SERVICES	0	0	0	0	0 40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0 41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	604	604	0	604 42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0 43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0 44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0 45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	8	2	10	0	10 46.00
100.00	TOTAL *	15,200	469,135	484,335	0	484,335 100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

	ADJUSTMENTS	TOTAL (col. 5	
	6.00	± col. 6)	
DI RECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	467,660 25.00
26.00	PHYSICIAN SERVICES	0	851 26.00
27.00	NURSE PRACTITIONER	0	201 27.00
28.00	REGISTERED NURSE	0	12,078 28.00
29.00	LPN/LVN	0	0 29.00
30.00	PHYSICAL THERAPY	0	0 30.00
31.00	OCCUPATIONAL THERAPY	0	0 31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0 32.00
33.00	MEDICAL SOCIAL SERVICES	0	1,210 33.00
34.00	SPIRITUAL COUNSELING	0	563 34.00
35.00	DIETARY COUNSELING	0	0 35.00
36.00	COUNSELING - OTHER	0	0 36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	1,158 37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0 38.00
39.00	PATIENT TRANSPORTATION	0	0 39.00
40.00	IMAGING SERVICES	0	0 40.00
41.00	LABS & DIAGNOSTICS	0	0 41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	604 42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0 42.50
43.00	OUTPATIENT SERVICES	0	0 43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0 44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0 45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	10 46.00
100.00	TOTAL *	0	484,335 100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET EXPENSES FOR ALLOCATION

Provider CCN: 14-0032

Period: From 07/01/2017

Worksheet 0-5

Hospice CCN: 14-1658

To 06/30/2018

Date/Time Prepared: 11/26/2018 3:39 pm

Descriptions	Hospice I		TOTAL EXPENSES (sum of col s. 1 + 2)	
	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)		
	1.00	2.00	3.00	
GENERAL SERVICE COST CENTERS				
1.00 CAP REL COSTS-BLDG & FIXT	0	0	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	91,487	1,653	93,140	2.00
3.00 EMPLOYEE BENEFITS DEPARTMENT	0	385,327	385,327	3.00
4.00 ADMINISTRATIVE & GENERAL	43,307	901,401	944,708	4.00
5.00 PLANT OPERATION & MAINTENANCE	8,489	0	8,489	5.00
6.00 LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00 HOUSEKEEPING	0	0	0	7.00
8.00 DIETARY	0	0	0	8.00
9.00 NURSING ADMINISTRATION	0	111,823	111,823	9.00
10.00 ROUTINE MEDICAL SUPPLIES	1,337	0	1,337	10.00
11.00 MEDICAL RECORDS	0	0	0	11.00
12.00 STAFF TRANSPORTATION	0	0	0	12.00
13.00 VOLUNTEER SERVICE COORDINATION	0	0	0	13.00
14.00 PHARMACY	207,116	0	207,116	14.00
15.00 PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	15.00
16.00 OTHER GENERAL SERVICE	0	0	0	16.00
17.00 PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	17.00
LEVEL OF CARE				
50.00 HOSPICE CONTINUOUS HOME CARE	0	0	0	50.00
51.00 HOSPICE ROUTINE HOME CARE	1,104,537	0	1,104,537	51.00
52.00 HOSPICE INPATIENT RESPIRE CARE	52,621	0	52,621	52.00
53.00 HOSPICE GENERAL INPATIENT CARE	484,335	0	484,335	53.00
NONREIMBURSABLE COST CENTERS				
60.00 BEREAVEMENT PROGRAM	0	0	0	60.00
61.00 VOLUNTEER PROGRAM	0	0	0	61.00
62.00 FUNDRAISING	0	0	0	62.00
63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	63.00
64.00 PALLIATIVE CARE PROGRAM	0	0	0	64.00
65.00 OTHER PHYSICIAN SERVICES	0	0	0	65.00
66.00 RESIDENTIAL CARE	0	0	0	66.00
67.00 ADVERTISING	0	0	0	67.00
68.00 TELEHEALTH/TELEMONITORING	0	0	0	68.00
69.00 THRIFT STORE	0	0	0	69.00
70.00 NURSING FACILITY ROOM & BOARD	0	0	0	70.00
71.00 OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	71.00
99.00 NEGATIVE COST CENTER	0	0	0	99.00
100.00 TOTAL	1,993,229	1,400,204	3,393,433	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0032

Period: From 07/01/2017

Worksheet 0-6

Hospice CCN: 14-1658

To 06/30/2018

Part I
Date/Time Prepared:
11/26/2018 3:39 pm

Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
	0	1.00	2.00	3.00	3A	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	93,140		93,140		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	385,327	0	0	385,327	3.00
4.00	ADMINISTRATIVE & GENERAL	944,708	0	93,140	69,875	1,107,723
5.00	PLANT OPERATION & MAINTENANCE	8,489	0	0	0	8,489
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0
7.00	HOUSEKEEPING	0	0	0	0	0
8.00	DIETARY	0	0	0	0	0
9.00	NURSING ADMINISTRATION	111,823	0	0	0	111,823
10.00	ROUTINE MEDICAL SUPPLIES	1,337	0	0	0	1,337
11.00	MEDICAL RECORDS	0	0	0	0	0
12.00	STAFF TRANSPORTATION	0	0	0	0	0
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0
14.00	PHARMACY	207,116	0	0	0	207,116
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0
16.00	OTHER GENERAL SERVICE	0	0	0	0	0
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	0
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0
51.00	HOSPICE ROUTINE HOME CARE	1,104,537			309,832	1,414,369
52.00	HOSPICE INPATIENT RESPIRE CARE	52,621	0	0	612	53,233
53.00	HOSPICE GENERAL INPATIENT CARE	484,335	0	0	5,008	489,343
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0
61.00	VOLUNTEER PROGRAM	0	0	0	0	0
62.00	FUNDRAISING	0	0	0	0	0
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0
66.00	RESIDENTIAL CARE	0	0	0	0	0
67.00	ADVERTISING	0	0	0	0	0
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0
69.00	THRIFT STORE	0	0	0	0	0
70.00	NURSING FACILITY ROOM & BOARD	0				0
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0
99.00	NEGATIVE COST CENTER	0	0	0	0	0
100.00	TOTAL	3,393,433	0	93,140	385,327	3,393,433

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS		Provider CCN: 14-0032	Period: From 07/01/2017	Worksheet 0-6
		Hospice CCN: 14-1658	To 06/30/2018	Part I
				Date/Time Prepared: 11/26/2018 3:39 pm

Descriptions	Hospice I					
	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
	4.00	5.00	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
3.00						3.00
4.00	1,107,723					4.00
5.00	4,114	12,603				5.00
6.00	0	0	0			6.00
7.00	0	0		0		7.00
8.00	0	0		0	0	8.00
9.00	54,193	0		0		9.00
10.00	648	0		0		10.00
11.00	0	0		0		11.00
12.00	0	0		0		12.00
13.00	0	0		0		13.00
14.00	100,375	0		0		14.00
15.00	0	0		0		15.00
16.00	0	0		0		16.00
17.00	0	0		0		17.00
LEVEL OF CARE						
50.00	0					50.00
51.00	685,445					51.00
52.00	25,798	1,305	0	0	0	52.00
53.00	237,150	11,298	0	0	0	53.00
NONREIMBURSABLE COST CENTERS						
60.00	0	0		0		60.00
61.00	0	0		0		61.00
62.00	0	0		0		62.00
63.00	0	0		0		63.00
64.00	0	0		0		64.00
65.00	0	0		0		65.00
66.00	0	0	0	0	0	66.00
67.00	0	0		0		67.00
68.00	0	0		0		68.00
69.00	0	0		0		69.00
70.00						70.00
71.00	0	0	0	0	0	71.00
99.00	0	0	0	0	0	99.00
100.00	1,107,723	12,603	0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS		Provider CCN: 14-0032	Period: From 07/01/2017	Worksheet 0-6
		Hospice CCN: 14-1658	To 06/30/2018	Part I
				Date/Time Prepared: 11/26/2018 3:39 pm

Descriptions	Hospice I					
	NURSING ADMINISTRATIVE	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
	9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
3.00						3.00
4.00						4.00
5.00						5.00
6.00						6.00
7.00						7.00
8.00						8.00
9.00	166,016					9.00
10.00	0	1,985				10.00
11.00	0		0			11.00
12.00	0			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						17.00
LEVEL OF CARE						
50.00	0	0	0	0	0	50.00
51.00	166,016	1,950	0	0	0	51.00
52.00	0	4	0	0	0	52.00
53.00	0	31	0	0	0	53.00
NONREIMBURSABLE COST CENTERS						
60.00	0				0	60.00
61.00	0				0	61.00
62.00	0				0	62.00
63.00	0				0	63.00
64.00	0				0	64.00
65.00	0				0	65.00
66.00	0				0	66.00
67.00	0				0	67.00
68.00	0				0	68.00
69.00	0				0	69.00
70.00						70.00
71.00	0				0	71.00
99.00	0	0	0	0	0	99.00
100.00	166,016	1,985	0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS		Provider CCN: 14-0032 Hospice CCN: 14-1658	Period: From 07/01/2017 To 06/30/2018	Worksheet 0-6 Part I Date/Time Prepared: 11/26/2018 3:39 pm
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Descriptions	Hospice I				TOTAL	
	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES		
	14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
3.00						3.00
4.00						4.00
5.00						5.00
6.00						6.00
7.00						7.00
8.00						8.00
9.00						9.00
10.00						10.00
11.00						11.00
12.00						12.00
13.00						13.00
14.00	307,491					14.00
15.00	0	0				15.00
16.00	0		0			16.00
17.00				0		17.00
LEVEL OF CARE						
50.00	0	0	0		0	50.00
51.00	301,938	0	0		2,569,718	51.00
52.00	542	0	0	0	80,882	52.00
53.00	5,011	0	0	0	742,833	53.00
NONREIMBURSABLE COST CENTERS						
60.00	0		0		0	60.00
61.00	0		0		0	61.00
62.00	0		0		0	62.00
63.00	0		0		0	63.00
64.00	0		0		0	64.00
65.00	0		0		0	65.00
66.00	0	0	0	0	0	66.00
67.00	0		0		0	67.00
68.00	0		0		0	68.00
69.00	0		0		0	69.00
70.00	0		0		0	70.00
71.00	0	0	0	0	0	71.00
99.00	0	0	0	0	0	99.00
100.00	307,491	0	0	0	3,393,433	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPI CE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0032
Hospice CCN: 14-1658

Period:
From 07/01/2017
To 06/30/2018

Worksheet 0-6
Part II
Date/Time Prepared:
11/26/2018 3:39 pm

Cost Center Descriptions		CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	912					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		2,751				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	1,169,621			3.00
4.00	ADMINISTRATIVE & GENERAL	912	2,751	212,097	-1,107,723	2,285,710	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	8,489	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	111,823	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	1,337	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	207,116	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			940,467	0	1,414,369	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	1,857	0	53,233	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	15,200	0	489,343	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		93,140	385,327		1,107,723	100.00
101.00	UNIT COST MULTIPLIER	0.000000	33.856779	0.329446		0.484630	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0032
Hospice CCN: 14-1658

Period:
From 07/01/2017
To 06/30/2018

Worksheet 0-6
Part II
Date/Time Prepared:
11/26/2018 3:39 pm

Cost Center Descriptions		Hospice I					
		PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	280					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		0			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		59,398	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0		0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					59,398	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	29	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	251	0	0	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	12,603	0	0	0	166,016	100.00
101.00	UNIT COST MULTIPLIER	45.010714	0.000000	0.000000	0.000000	2.794976	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0032
Hospice CCN: 14-1658

Period:
From 07/01/2017
To 06/30/2018

Worksheet 0-6
Part II
Date/Time Prepared:
11/26/2018 3:39 pm

Cost Center Descriptions		Hospice I					
		ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	16,214					10.00
11.00	MEDICAL RECORDS		0				11.00
12.00	STAFF TRANSPORTATION			0			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	207,116	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	15,932	0	0	0	203,376	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	29	0	0	0	365	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	253	0	0	0	3,375	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD			0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	1,985	0	0	0	307,491	100.00
101.00	UNIT COST MULTIPLIER	0.122425	0.000000	0.000000	0.000000	1.484632	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0032
Hospice CCN: 14-1658

Period:
From 07/01/2017
To 06/30/2018

Worksheet 0-6
Part II
Date/Time Prepared:
11/26/2018 3:39 pm

Cost Center Descriptions		Hospice I			
		PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)	
GENERAL SERVICE COST CENTERS		15.00	16.00	17.00	
1.00	CAP REL COSTS-BLDG & FIXT				1.00
2.00	CAP REL COSTS-MVBLE EQUIP				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT				3.00
4.00	ADMINISTRATIVE & GENERAL				4.00
5.00	PLANT OPERATION & MAINTENANCE				5.00
6.00	LAUNDRY & LINEN SERVICE				6.00
7.00	HOUSEKEEPING				7.00
8.00	DIETARY				8.00
9.00	NURSING ADMINISTRATION				9.00
10.00	ROUTINE MEDICAL SUPPLIES				10.00
11.00	MEDICAL RECORDS				11.00
12.00	STAFF TRANSPORTATION				12.00
13.00	VOLUNTEER SERVICE COORDINATION				13.00
14.00	PHARMACY				14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			15.00
16.00	OTHER GENERAL SERVICE		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0	17.00
LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0		51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	53.00
NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM		0		60.00
61.00	VOLUNTEER PROGRAM		0		61.00
62.00	FUNDRAISING		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0		63.00
64.00	PALLIATIVE CARE PROGRAM		0		64.00
65.00	OTHER PHYSICIAN SERVICES		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	66.00
67.00	ADVERTISING		0		67.00
68.00	TELEHEALTH/TELEMONITORING		0		68.00
69.00	THRIFT STORE		0		69.00
70.00	NURSING FACILITY ROOM & BOARD		0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	71.00
99.00	NEGATIVE COST CENTER		0		99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		0	0	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000	101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

Provider CCN: 14-0032
Hospice CCN: 14-1658

Period: From 07/01/2017 To 06/30/2018

Worksheet 0-7
Date/Time Prepared: 11/26/2018 3:39 pm

Cost Center Descriptions		From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records)			
				HCHC	HRHC	HIRC	
				0	1.00	2.00	
ANCILLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	66.00	0.535435	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.265840	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00					3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.237404	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.203514	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0.347710	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	BACTERIOLOGY & MICROBIOLOGY	76.00	0.000000	0	0	0	10.00
10.01	VASCULAR LAB	76.01	0.161462	0	0	0	10.01
10.03	WOUND CARE	76.03	0.319343	0	0	0	10.03
10.97	CARDIAC REHABILITATION	76.97	0.293966	0	0	0	10.97
11.00	Totals (sum of lines 1-11)						11.00
Cost Center Descriptions		Charges by LOC (from Provider Records)	Shared Service Costs by LOC				
			HGIP	HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)
			5.00	6.00	7.00	8.00	9.00
ANCILLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	0	0	0	0	0	2.00
3.00	SPEECH PATHOLOGY						3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	10.00
10.01	VASCULAR LAB	0	0	0	0	0	10.01
10.03	WOUND CARE	0	0	0	0	0	10.03
10.97	CARDIAC REHABILITATION	0	0	0	0	0	10.97
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 14-0032

Period: From 07/01/2017

Worksheet 0-8

Hospice CCN: 14-1658

To 06/30/2018

Date/Time Prepared: 11/26/2018 3:39 pm

		Hospice I		TOTAL	
		TITLE XVII MEDI CARE	TITLE XIX MEDI CAID		
		1.00	2.00	3.00	
HOSPICE CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)				4.00
5.00	Program cost (line 3 times line 4)	0	0	0	5.00
HOSPICE ROUTINE HOME CARE					
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, line 11)			2,569,718	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			15,932	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			161.29	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	14,203	858		9.00
10.00	Program cost (line 8 times line 9)	2,290,802	138,387		10.00
HOSPICE INPATIENT RESPITE CARE					
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11)			80,882	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			29	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			2,789.03	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	29	0		14.00
15.00	Program cost (line 13 times line 14)	80,882	0		15.00
HOSPICE GENERAL INPATIENT CARE					
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11)			742,833	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			253	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			2,936.10	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	236	8		19.00
20.00	Program cost (line 18 times line 19)	692,920	23,489		20.00
TOTAL HOSPICE CARE					
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			3,393,433	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			16,214	22.00
23.00	Average cost per diem (line 21 divided by line 22)			209.29	23.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0032	Period: From 07/01/2017 To 06/30/2018	Worksheet L Parts I-III Date/Time Prepared: 11/26/2018 3:39 pm
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,464,959	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		28,193	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)		41.60	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		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)		1,493,152	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