

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: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/28/2019 11:34 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: 5/28/2019 Time: 11:34 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 SSM HEALTH ST. MARY'S HOSPITAL ( 14-0034 ) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) KAREN REWERTS  
 Officer or Administrator of Provider(s)

SYSTEM VP OF FINANCE  
 Title

(Dated when report is electronically signed.)  
 Date

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	-211,476	-48,741	0	0	1.00
2.00 Subprovider - IPF	0	42,574	-2		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
12.20 OPT I	0		0		0	12.20
200.00 Total	0	-168,902	-48,743	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 11:34 am
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1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 400 NORTH PLEASANT AVENUE			PO Box:						1.00	
2.00	City: CENTRALIA			State: IL		Zip Code: 62801-		County: MARI ON		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	6.00	7.00	8.00	
								V	XVIII	XIX	
Hospital and Hospital -Based Component Identification:											
3.00	Hospital		SSM HEALTH ST. MARY'S HOSPITAL	140034	99914	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF		SSM HEALTH ST. MARYS PSYCH	14S034	99914	4	01/01/2002	N	P	P	4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF										7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital -Based SNF										9.00
10.00	Hospital -Based NF										10.00
11.00	Hospital -Based OLTC										11.00
12.00	Hospital -Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital -Based Hospice										14.00
15.00	Hospital -Based Health Clinic - RHC										15.00
16.00	Hospital -Based Health Clinic - FQHC										16.00
17.00	Hospital -Based (CMHC) I										17.00
17.10	Hospital -Based (CORF) I										17.10
17.20	Hospital -Based (OPT) I		ST MARYS WORK SAFETY INSTITUTE	146668	99914		03/08/2000	N	O	N	17.20
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2018	12/31/2018			20.00
21.00	Type of Control (see instructions)						1				21.00
						1.00	2.00	3.00			

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0034		Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 11:34 am			
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
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.	1,024	207	0	0	1,414	114	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	
						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.							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.					1		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.					01/01/2018	12/31/2018	38.00	
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00	
						V	XVIII	XIX	
						1.00	2.00	3.00	
<b>Prospective Payment System (PPS)-Capital</b>									
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
<b>Teaching Hospitals</b>									
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0034		Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 11:34 am	
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	N					60.00
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00		61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00		61.20
						1.00	
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
<b>Teaching Hospitals that Claim Residents in Nonprovider Settings</b>							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))			
		1.00	2.00	3.00			
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0034

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

Worksheet S-2  
Part I  
Date/Time Prepared:  
5/28/2019 11:34 am

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))			
		1.00	2.00	3.00	4.00	5.00			
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00		
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))			
				1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010									
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00		
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))			
		1.00	2.00	3.00	4.00	5.00			
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00		
						1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.					Y			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					N	N	0	71.00
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.					N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)							0	76.00

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				1.00			
<b>Long Term Care Hospital PPS</b>							
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	
<b>TEFRA Providers</b>							
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	
<b>Title V and XIX Services</b>							
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	
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	
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	
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	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N		N	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00		0.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N		N	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00		0.00	
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	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y		Y	
98.02	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	
98.03	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	
98.04	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	
98.05	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	
98.06	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	
<b>Rural Providers</b>							
105.00	Does this hospital qualify as a CAH?			N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.					107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108.00	
				Physical		Occupational	
				1.00		2.00	
				Speech		Respiratory	
				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	
				1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N		110.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 11:34 am		
		1.00	2.00			
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00
		1.00	2.00	3.00		
<b>Miscellaneous Cost Reporting Information</b>						
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.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	51,150	8,268			0118.01
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		Y		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
<b>Transplant Center Information</b>						
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
<b>All Providers</b>						
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		269020		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0034		Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 11:34 am							
1.00		2.00		3.00									
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.													
141.00	Name: SSM HEALTH	Contractor's Name: A		Contractor's Number: 05301		141.00							
142.00	Street: 10101 WOODFIELD LANE	PO Box:		Zip Code: 63132		142.00							
143.00	City: ST. LOUIS	State: MO		143.00									
							1.00						
144.00	Are provider based physicians' costs included in Worksheet A?						Y	144.00					
							1.00						
							2.00						
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.						Y	Y	145.00				
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.						N		146.00				
							1.00						
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N	147.00					
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N	148.00					
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N	149.00					
		Part A		Part B		Title V		Title XIX					
		1.00		2.00		3.00		4.00					
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)													
155.00	Hospital	N		N		N		N		155.00			
156.00	Subprovider - IPF	N		N		N		N		156.00			
157.00	Subprovider - IRF	N		N		N		N		157.00			
158.00	SUBPROVIDER									158.00			
159.00	SNF	N		N		N		N		159.00			
160.00	HOME HEALTH AGENCY	N		N		N		N		160.00			
161.00	CMHC									161.00			
161.10	CORF									161.10			
161.20	OPT									161.20			
							1.00						
165.00	Multi campus Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00					
		Name		County		State		Zip Code		CBSA		FTE/Campus	
		0		1.00		2.00		3.00		4.00		5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		166.00				
							1.00						
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act													
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						Y		167.00				
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00				
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01				
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						9.99		169.00				
							Beginning		Ending				
							1.00		2.00				
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)						08/02/2018		10/30/2018				170.00
							1.00		2.00				
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N		0				171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0034		Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part II Date/Time Prepared: 5/28/2019 11:34 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N			14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N			15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			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)	Y	04/03/2017	Y	04/03/2017		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: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/28/2019 11:34 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
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
<b>Interest Expense</b>					
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
<b>Purchased Services</b>					
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
<b>Provider-Based Physicians</b>					
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	
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?		Y		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.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00		2.00	
<b>Cost Report Preparer Contact Information</b>					
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.	ERIC		LAMOND	41.00
42.00	Enter the employer/company name of the cost report preparer.	SSM HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-989-3162		ERIC.LAMOND@SSMHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/28/2019 11:34 am
		3.00		
<b>Cost Report Preparer Contact Information</b>				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER - GOVERNEMENT REIMBURSEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0034

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/28/2019 11:34 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	73	26,645	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)		73	26,645	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	9	3,285	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)		82	29,930	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	24	8,760		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
25.20 CMHC - OPT	99.20				0	25.20
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)		106				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: 14-0034

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/28/2019 11:34 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	8,211	625	12,242			1.00
2.00 HMO and other (see instructions)	978	1,621				2.00
3.00 HMO IPF Subprovider	0	1,107				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	8,211	625	12,242			7.00
8.00 INTENSIVE CARE UNIT	942	134	1,501			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		265	514			13.00
14.00 Total (see instructions)	9,153	1,024	14,257	0.00	530.58	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	1,393	1,604	5,050	0.00	33.92	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)			0			24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
25.20 CMHC - OPT	0	0	0	0.00	0.00	25.20
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	564.50	27.00
28.00 Observation Bed Days		206	2,068			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			225			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	114	136			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: 14-0034

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/28/2019 11:34 am

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	2,249	624	4,423	1.00
2.00	HMO and other (see instructions)			232	536		2.00
3.00	HMO IPF Subprovider				269		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	2,249	624	4,423	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	229	0	1,108	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0.00					25.10
25.20	CMHC - OPT	0.00					25.20
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: 14-0034

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/28/2019 11:34 am

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	33,608,650	0	33,608,650	1,174,445.66	28.62
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		731,795	0	731,795	3,585.00	204.13
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		2,127,517	0	2,127,517	76,591.00	27.78
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract Labor: Direct Patient Care		157,279	0	157,279	6,102.49	25.77
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		427,765	0	427,765	4,277.65	100.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		3,572,003	0	3,572,003	102,637.41	34.80
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) (see instructions)		13,432,693	0	13,432,693		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		770,942	0	770,942		
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		37,412	0	37,412		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		2,812	0	2,812		
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)		1,158,897	0	1,158,897		
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		
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26.00	Employee Benefits Department	4.00	150,605	0	150,605	1,386.21	108.65
27.00	Administrative & General	5.00	3,209,918	-34,427	3,175,491	84,456.34	37.60

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0034

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/28/2019 11:34 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		222,488	0	222,488	1,720.77	129.30	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	670,998	149,079	820,077	28,648.83	28.63	30.00
31.00	Laundry & Linen Service	8.00	100,964	-4,386	96,578	6,883.28	14.03	31.00
32.00	Housekeeping	9.00	994,815	-96,041	898,774	71,308.63	12.60	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	762,466	-537,675	224,791	15,459.83	14.54	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	537,675	537,675	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	941,632	0	941,632	25,467.73	36.97	38.00
39.00	Central Services and Supply	14.00	319,051	-198,106	120,945	3,956.88	30.57	39.00
40.00	Pharmacy	15.00	1,085,099	0	1,085,099	29,488.70	36.80	40.00
41.00	Medical Records & Medical Records Library	16.00	577,761	-262	577,499	26,956.05	21.42	41.00
42.00	Social Service	17.00	758,381	-386	757,995	23,898.33	31.72	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0034

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
5/28/2019 11:34 am

	Worksheet A	Amount	Recl assi fi cation	Adjusted	Paid Hours	Average Hourly	
	Line Number	Reported	on of Salaries	Salaries	Related to	Wage (col. 4 ÷	
	1.00	2.00	(from	(col. 2 ± col.	Salaries in	col. 5)	
			Worksheet A-6)	3)	col. 4		
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	33,831,138	0	33,831,138	1,176,166.43	28.76	1.00
2.00	Excluded area salaries (see instructions)	2,127,517	0	2,127,517	76,591.00	27.78	2.00
3.00	Subtotal salaries (line 1 minus line 2)	31,703,621	0	31,703,621	1,099,575.43	28.83	3.00
4.00	Subtotal other wages & related costs (see inst.)	4,157,047	0	4,157,047	113,017.55	36.78	4.00
5.00	Subtotal wage-related costs (see inst.)	14,629,002	0	14,629,002	0.00	46.14	5.00
6.00	Total (sum of lines 3 thru 5)	50,489,670	0	50,489,670	1,212,592.98	41.64	6.00
7.00	Total overhead cost (see instructions)	9,794,178	-184,529	9,609,649	319,631.58	30.06	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part IV Date/Time Prepared: 5/28/2019 11:34 am
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		Amount Reported	
		1.00	
<b>PART IV - WAGE RELATED COSTS</b>			
<b>Part A - Core List</b>			
<b>RETIREMENT COST</b>			
1.00	401K Employer Contributions	966,637	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)	1,890,333	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>			
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
<b>HEALTH AND INSURANCE COST</b>			
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)	7,073,746	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	419,955	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	172,389	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)	152,402	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	83,592	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
<b>TAXES</b>			
17.00	FICA-Employers Portion Only	2,381,982	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	55,999	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
<b>OTHER</b>			
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	816,476	22.00
23.00	Tuition Reimbursement	190,125	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	14,203,636	24.00
<b>Part B - Other than Core Related Cost</b>			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part V Date/Time Prepared: 5/28/2019 11:34 am
Cost Center Description			Contract Labor	Benefit Cost
			1.00	2.00
<b>PART V - Contract Labor and Benefit Cost</b>				
<b>Hospital and Hospital-Based Component Identification:</b>				
1.00	Total facility's contract labor and benefit cost		157,279	14,203,636
2.00	Hospital		157,279	14,089,247
3.00	Subprovider - IPF		0	6,723
4.00	Subprovider - IRF			
5.00	Subprovider - (Other)		0	0
6.00	Swing Beds - SNF		0	0
7.00	Swing Beds - NF		0	0
8.00	Hospital-Based SNF			
9.00	Hospital-Based NF			
10.00	Hospital-Based OLTC			
11.00	Hospital-Based HHA			
12.00	Separately Certified ASC			
13.00	Hospital-Based Hospice			
14.00	Hospital-Based Health Clinic RHC			
15.00	Hospital-Based Health Clinic FQHC			
16.00	Hospital-Based-CMHC			
16.10	Hospital-Based-CMHC 10		0	0
16.20	Hospital-Based-CMHC 20		0	0
17.00	Renal Dialysis		0	0
18.00	Other		0	107,666

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet S-10 Date/Time Prepared: 5/28/2019 11:34 am
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			1.00	
<b>Uncompensated and indigent care cost computation</b>				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.251626	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		9,688,723	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		8,041,261	5.00
6.00	Medicaid charges		78,274,328	6.00
7.00	Medicaid cost (line 1 times line 6)		19,695,856	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)		1,965,872	8.00
<b>Children's Health Insurance Program (CHIP) (see instructions for each line)</b>				
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
<b>Other state or local government indigent care program (see instructions for each line)</b>				
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
<b>Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)</b>				
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)		1,965,872	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
<b>Uncompensated Care (see instructions for each line)</b>				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	2,564,590	1,354,900	3,919,490
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	645,318	1,354,900	2,000,218
22.00	Payments received from patients for amounts previously written off as charity care	166,704	156,423	323,127
23.00	Cost of charity care (line 21 minus line 22)	478,614	1,198,477	1,677,091
			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)		4,440,658	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		556,192	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		855,679	27.01
28.00	Non-Medicare bad debt expense (see instructions)		3,584,979	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		1,201,561	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		2,878,652	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		4,844,524	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0034

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

Worksheet A  
Date/Time Prepared:  
5/28/2019 11:34 am

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)		
	1.00	2.00	3.00	4.00	5.00		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100 CAP REL COSTS-BLDG & FIXT		3,535,258	3,535,258	227,802	3,763,060	1.00	
2.00 00200 CAP REL COSTS-MVBLE EQUIP		2,390,740	2,390,740	0	2,390,740	2.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	150,605	14,083,591	14,234,196	0	14,234,196	4.00	
5.00 00500 ADMIN STRATIVE & GENERAL	3,209,918	17,048,247	20,258,165	-153,641	20,104,524	5.00	
6.00 00600 MAINTENANCE & REPAIRS	0	0	0	0	0	6.00	
7.00 00700 OPERATION OF PLANT	670,998	3,771,444	4,442,442	149,079	4,591,521	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	100,964	300,701	401,665	-4,386	397,279	8.00	
9.00 00900 HOUSEKEEPING	994,815	306,801	1,301,616	-96,041	1,205,575	9.00	
10.00 01000 DIETARY	762,466	612,053	1,374,519	-967,526	406,993	10.00	
11.00 01100 CAFETERIA	0	0	0	967,526	967,526	11.00	
13.00 01300 NURSING ADMINISTRATION	941,632	91,028	1,032,660	0	1,032,660	13.00	
14.00 01400 CENTRAL SERVICE & SUPPLY	319,051	194,240	513,291	-251,899	261,392	14.00	
15.00 01500 PHARMACY	1,085,099	3,739,115	4,824,214	-3,486,982	1,337,232	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	577,761	152,010	729,771	-262	729,509	16.00	
17.00 01700 SOCIAL SERVICE	758,381	282,032	1,040,413	-386	1,040,027	17.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000 ADULTS & PEDIATRICS	5,654,642	978,368	6,633,010	159,408	6,792,418	30.00	
31.00 03100 INTENSIVE CARE UNIT	1,675,087	769,999	2,445,086	-532,398	1,912,688	31.00	
40.00 04000 SUBPROVIDER - I/PF	1,975,377	49,856	2,025,233	-15,671	2,009,562	40.00	
43.00 04300 NURSERY	0	0	0	165,882	165,882	43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	1,747,319	2,842,284	4,589,603	-2,349,995	2,239,608	50.00	
51.00 05100 RECOVERY ROOM	305,416	13,851	319,267	-11,636	307,631	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	1,033,029	156,818	1,189,847	-439,740	750,107	52.00	
53.00 05300 ANESTHESIOLOGY	222,895	2,676,137	2,899,032	-120,767	2,778,265	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	967,494	324,676	1,292,170	-60,562	1,231,608	54.00	
55.00 05500 RADIOLOGY - THERAPEUTIC	987,918	366,538	1,354,456	-8,195	1,346,261	55.00	
56.00 05600 RADIOISOTOPE	168,193	309,275	477,468	-2,131	475,337	56.00	
57.00 05700 CT SCAN	342,866	86,136	429,002	-46,140	382,862	57.00	
58.00 05800 MRI	139,429	50,720	190,149	-37,436	152,713	58.00	
59.00 05900 CARDIAC CATHETERIZATION	173,555	230,359	403,914	-186,406	217,508	59.00	
60.00 06000 LABORATORY	1,619,419	2,408,726	4,028,145	-70,661	3,957,484	60.00	
64.00 06400 INTRAVENOUS THERAPY	222,665	49,532	272,197	-36,965	235,232	64.00	
65.00 06500 RESPIRATORY THERAPY	981,485	203,733	1,185,218	65,010	1,250,228	65.00	
66.00 06600 PHYSICAL THERAPY	1,045,097	314,879	1,359,976	-15,193	1,344,783	66.00	
66.01 06601 CLINICAL NUTRITION	171,797	1,481	173,278	0	173,278	66.01	
67.00 06700 OCCUPATIONAL THERAPY	137,139	3,740	140,879	-750	140,129	67.00	
68.00 06800 SPEECH PATHOLOGY	101,759	6,295	108,054	-471	107,583	68.00	
69.00 06900 ELECTROCARDIOLOGY	619,021	462,676	1,081,697	-15,020	1,066,677	69.00	
69.01 06901 CARDIAC REHABILITATION	80,495	1,418	81,913	-846	81,067	69.01	
70.00 07000 ELECTROENCEPHALOGRAPHY	99,610	209,701	309,311	-2,637	306,674	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	3,474,783	3,474,783	71.00	
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	820,802	820,802	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	3,486,982	3,486,982	73.00	
74.00 07400 RENAL DIALYSIS	0	155,272	155,272	-808	154,464	74.00	
76.00 03330 ENDOSCOPY	147,697	68,635	216,332	-54,362	161,970	76.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000 CLINIC	1,328,890	789,850	2,118,740	-80,925	2,037,815	90.00	
91.00 09100 EMERGENCY	1,936,526	1,689,204	3,625,730	-357,848	3,267,882	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT)						92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10 09910 CORF	0	0	0	0	0	99.10	
99.20 09920 OPT	0	0	0	0	0	99.20	
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	33,456,510	61,727,419	95,183,929	108,588	95,292,517	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000 GIFT FLOWER COFFEE SHOP & CAN	33,295	1,725	35,020	0	35,020	190.00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	53,444	53,444	-95,820	-42,376	192.00	
194.00 07950 NONREIMBURSABLE	118,845	128,398	247,243	-12,768	234,475	194.00	
194.01 07951 RETAIL PHARMACY	0	148,768	148,768	0	148,768	194.01	
200.00	TOTAL (SUM OF LINES 118 through 199)	33,608,650	62,059,754	95,668,404	0	95,668,404	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0034

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

Worksheet A  
Date/Time Prepared:  
5/28/2019 11:34 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-27,375	3,735,685	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-218,639	2,172,101	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-5,283,533	8,950,663	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-5,046,160	15,058,364	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-549,505	4,042,016	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	397,279	8.00
9.00	00900	HOUSEKEEPING	-11,704	1,193,871	9.00
10.00	01000	DIETARY	0	406,993	10.00
11.00	01100	CAFETERIA	-263,210	704,316	11.00
13.00	01300	NURSING ADMINISTRATION	-496	1,032,164	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	261,392	14.00
15.00	01500	PHARMACY	-36,275	1,300,957	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5,172	724,337	16.00
17.00	01700	SOCIAL SERVICE	0	1,040,027	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-664,195	6,128,223	30.00
31.00	03100	INTENSIVE CARE UNIT	-5,193	1,907,495	31.00
40.00	04000	SUBPROVIDER - IPF	-14,000	1,995,562	40.00
43.00	04300	NURSERY	0	165,882	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-34,830	2,204,778	50.00
51.00	05100	RECOVERY ROOM	0	307,631	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-307	749,800	52.00
53.00	05300	ANESTHESIOLOGY	-2,452,307	325,958	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-210,193	1,021,415	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	-360,797	985,464	55.00
56.00	05600	RADIOISOTOPE	-23,924	451,413	56.00
57.00	05700	CT SCAN	0	382,862	57.00
58.00	05800	MRI	0	152,713	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	217,508	59.00
60.00	06000	LABORATORY	-7,932	3,949,552	60.00
64.00	06400	INTRAVENOUS THERAPY	0	235,232	64.00
65.00	06500	RESPIRATORY THERAPY	-47,532	1,202,696	65.00
66.00	06600	PHYSICAL THERAPY	-144,451	1,200,332	66.00
66.01	06601	CLINICAL NUTRITION	0	173,278	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	140,129	67.00
68.00	06800	SPEECH PATHOLOGY	-8,280	99,303	68.00
69.00	06900	ELECTROCARDIOLOGY	-322,457	744,220	69.00
69.01	06901	CARDIAC REHABILITATION	-12,681	68,386	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	-200,679	105,995	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	-81,419	3,393,364	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	820,802	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,486,982	73.00
74.00	07400	RENAL DIALYSIS	0	154,464	74.00
76.00	03330	ENDOSCOPY	-13,150	148,820	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	-234,689	1,803,126	90.00
91.00	09100	EMERGENCY	-1,238,577	2,029,305	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
99.10	09910	CORF	0	0	99.10
99.20	09920	OPT	0	0	99.20
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-17,519,662	77,772,855	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	35,020	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	-42,376	192.00
194.00	07950	NONREIMBURSABLE	0	234,475	194.00
194.01	07951	RETAIL PHARMACY	0	148,768	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-17,519,662	78,148,742	200.00

RECLASSIFICATIONS

Provider CCN: 14-0034

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

Worksheet A-6

Date/Time Prepared:  
5/28/2019 11:34 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - L &amp; D AND NURSERY RECLASS</b>					
1.00	ADULTS & PEDIATRICS	30.00	411,995	139,757	1.00
2.00	INTENSIVE CARE UNIT	31.00	794	154	2.00
3.00	NURSERY	43.00	144,019	21,863	3.00
	O		556,808	161,774	
<b>C - RECLASS FROM DIETARY TO CAFETERIA</b>					
1.00	CAFETERIA	11.00	537,675	429,851	1.00
	O		537,675	429,851	
<b>D - IV PUMP COST</b>					
1.00	ADULTS & PEDIATRICS	30.00	0	16,970	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	322	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	7	3.00
4.00	INTRAVENOUS THERAPY	64.00	0	3,671	4.00
5.00	ENDOSCOPY	76.00	0	2	5.00
6.00	EMERGENCY	91.00	0	3,998	6.00
	O		0	24,970	
<b>G - CENTRAL SERVICES RECLASS</b>					
1.00	OPERATING ROOM	50.00	48,001	6,983	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	812	118	2.00
3.00	CARDIAC CATHETERIZATION	59.00	41,880	6,093	3.00
4.00	RESPIRATORY THERAPY	65.00	103,986	15,128	4.00
5.00	PHYSICAL THERAPY	66.00	2,714	395	5.00
6.00	SPEECH PATHOLOGY	68.00	297	43	6.00
7.00	ENDOSCOPY	76.00	20	3	7.00
8.00	CLINIC	90.00	396	60	8.00
	O		198,106	28,823	
<b>L - RECLASS UTILITIES</b>					
1.00	OPERATION OF PLANT	7.00	149,079	0	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
	O		149,079	0	
<b>M - RECLASS REAL ESTATE TAXES</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	112,644	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	O		0	112,644	
<b>O - BUILDING INSURANCE</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	115,158	1.00
	O		0	115,158	
<b>P - C. SUPPLIES - MEDICAL AND IMPL SUPPL</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	3,474,783	1.00
2.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00	0	820,802	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

Provider CCN: 14-0034

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

Worksheet A-6  
Date/Time Prepared:  
5/28/2019 11:34 am

Increases						
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
				0	4,295,585	
<b>R - PHARM-DRUGS CHARGED TO PATIENTS</b>						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,486,982		1.00
				0	3,486,982	
500.00	Grand Total: Increases		1,441,668	8,655,787		500.00

RECLASSIFICATIONS

Provider CCN: 14-0034

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

Worksheet A-6  
Date/Time Prepared:  
5/28/2019 11:34 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - L&amp;D AND NURSERY RECLASS</b>							
1.00	ADULTS & PEDIATRICS	30.00	794	154	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	250,801	115,288	0		2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	305,213	46,332	0		3.00
	O		556,808	161,774			
<b>C - RECLASS FROM DIETARY TO CAFETERIA</b>							
1.00	DIETARY	10.00	537,675	429,851	0		1.00
	O		537,675	429,851			
<b>D - IV PUMP COST</b>							
1.00	CENTRAL SERVICE & SUPPLY	14.00	0	24,970	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	O		0	24,970			
<b>G - CENTRAL SERVICES RECLASS</b>							
1.00	CENTRAL SERVICE & SUPPLY	14.00	198,106	28,823	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
	O		198,106	28,823			
<b>L - RECLASS UTILITIES</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	34,427	0	0		1.00
2.00	LAUNDRY & LINEN SERVICE	8.00	4,386	0	0		2.00
3.00	HOUSEKEEPING	9.00	96,041	0	0		3.00
4.00	MEDICAL RECORDS & LIBRARY	16.00	262	0	0		4.00
5.00	SOCIAL SERVICE	17.00	386	0	0		5.00
6.00	OPERATING ROOM	50.00	153	0	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	99	0	0		7.00
8.00	LABORATORY	60.00	55	0	0		8.00
9.00	RESPIRATORY THERAPY	65.00	170	0	0		9.00
10.00	PHYSICAL THERAPY	66.00	9,744	0	0		10.00
11.00	ELECTROCARDIOLOGY	69.00	34	0	0		11.00
12.00	CLINIC	90.00	3,322	0	0		12.00
	O		149,079	0			
<b>M - RECLASS REAL ESTATE TAXES</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,056	13		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	95,820	13		2.00
3.00	NONREIMBURSABLE	194.00	0	12,768	13		3.00
	O		0	112,644			
<b>O - BUILDING INSURANCE</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	115,158	12		1.00
	O		0	115,158			
<b>P - C. SUPPLIES - MEDICAL AND IMPL SUPPL</b>							
1.00	ADULTS & PEDIATRICS	30.00	0	408,366	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	167,579	0		2.00
3.00	SUBPROVIDER - IPF	40.00	0	15,671	0		3.00
4.00	OPERATING ROOM	50.00	0	2,404,826	0		4.00
5.00	RECOVERY ROOM	51.00	0	11,636	0		5.00
6.00	DELIVERY ROOM & LABOR ROOM	52.00	0	88,195	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	120,767	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	61,400	0		8.00
9.00	RADIOLOGY - THERAPEUTIC	55.00	0	8,195	0		9.00
10.00	RADIOISOTOPE	56.00	0	2,131	0		10.00
11.00	CT SCAN	57.00	0	46,140	0		11.00
12.00	MRI	58.00	0	37,436	0		12.00
13.00	CARDIAC CATHETERIZATION	59.00	0	234,379	0		13.00
14.00	LABORATORY	60.00	0	70,606	0		14.00
15.00	INTRAVENOUS THERAPY	64.00	0	40,636	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	53,934	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	8,558	0		17.00
18.00	OCCUPATIONAL THERAPY	67.00	0	750	0		18.00
19.00	SPEECH PATHOLOGY	68.00	0	811	0		19.00
20.00	ELECTROCARDIOLOGY	69.00	0	14,986	0		20.00
21.00	CARDIAC REHABILITATION	69.01	0	846	0		21.00
22.00	ELECTROENCEPHALOGRAPHY	70.00	0	2,637	0		22.00
23.00	RENAL DIALYSIS	74.00	0	808	0		23.00
24.00	ENDOSCOPY	76.00	0	54,387	0		24.00
25.00	CLINIC	90.00	0	78,059	0		25.00

Provider CCN: 14-0034

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

Worksheet A-6  
Date/Time Prepared:  
5/28/2019 11:34 am

Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
26.00	EMERGENCY	91.00	0	361,846	0		26.00
			0	4,295,585			
R - PHARM-DRUGS CHARGED TO PATIENTS							
1.00	PHARMACY	15.00	0	3,486,982	0		1.00
			0	3,486,982			
500.00	Grand Total: Decreases		1,441,668	8,655,787			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0034

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
5/28/2019 11:34 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	1,259,000	251,399	0	251,399	0	1.00
2.00	Land Improvements	667,527	2,963,380	0	2,963,380	0	2.00
3.00	Buildings and Fixtures	36,718,330	128,533	0	128,533	0	3.00
4.00	Building Improvements	0	3,569,330	0	3,569,330	0	4.00
5.00	Fixed Equipment	4,547,603	0	0	0	0	5.00
6.00	Movable Equipment	23,605,877	0	0	0	120,629	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	66,798,337	6,912,642	0	6,912,642	120,629	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	66,798,337	6,912,642	0	6,912,642	120,629	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	1,510,399	0				1.00
2.00	Land Improvements	3,630,907	0				2.00
3.00	Buildings and Fixtures	36,846,863	0				3.00
4.00	Building Improvements	3,569,330	0				4.00
5.00	Fixed Equipment	4,547,603	0				5.00
6.00	Movable Equipment	23,485,248	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	73,590,350	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	73,590,350	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0034

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
5/28/2019 11:34 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	1,963,063	0	1,572,195	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,390,740	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,353,803	0	1,572,195	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	3,535,258				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,390,740				2.00
3.00	Total (sum of lines 1-2)	0	5,925,998				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0034

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
5/28/2019 11:34 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	43,192,459	0	43,192,459	0.646610	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	23,605,877	0	23,605,877	0.353390	0	2.00
3.00	Total (sum of lines 1-2)	66,798,336	0	66,798,336	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	1,935,688	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,936,710	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,872,398	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	1,572,195	115,158	112,644	0	3,735,685	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	-764,609	0	0	0	2,172,101	2.00
3.00	Total (sum of lines 1-2)	807,586	115,158	112,644	0	5,907,786	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0034

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

Worksheet A-8

Date/Time Prepared:  
5/28/2019 11:34 am

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
				3.00	4.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0 1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0 2.00
3.00	Investment income - other (chapter 2)		0			0.00	0 3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-574,069		ADMINISTRATIVE & GENERAL	5.00	0 4.00
5.00	Refunds and rebates of expenses (chapter 8)		0			0.00	0 5.00
6.00	Rental of provider space by suppliers (chapter 8)		0			0.00	0 6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	0		ADMINISTRATIVE & GENERAL	5.00	0 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	-5,809,426				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	-9,953,395				0 12.00
13.00	Laundry and linen service		0			0.00	0 13.00
14.00	Cafeteria-employees and guests	B	-263,210		CAFETERIA	11.00	0 14.00
15.00	Rental of quarters to employee and others		0			0.00	0 15.00
16.00	Sale of medical and surgical supplies to other than patients		0			0.00	0 16.00
17.00	Sale of drugs to other than patients		0			0.00	0 17.00
18.00	Sale of medical records and abstracts	A	-5,122		MEDICAL RECORDS & LIBRARY	16.00	0 18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0			0.00	0 19.00
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0			0.00	0 19.01
19.02	Nursing and allied health education (tuition, fees, books, etc.)		0			0.00	0 19.02
19.03	Nursing and allied health education (tuition, fees, books, etc.)		0			0.00	0 19.03
20.00	Vending machines		0			0.00	0 20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	0 21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	0 22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0		RESPIRATORY THERAPY	65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0		PHYSICAL THERAPY	66.00	24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0		*** Cost Center Deleted ***	114.00	25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-144,737		CAP REL COSTS-BLDG & FIXT	1.00	9 26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-29,808		CAP REL COSTS-MVBLE EQUIP	2.00	9 27.00
28.00	Non-physician Anesthetist	A	0		*** Cost Center Deleted ***	19.00	28.00
29.00	Physicians' assistant		0			0.00	0 29.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0034

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

Worksheet A-8

Date/Time Prepared:  
5/28/2019 11:34 am

30.00	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
	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00		0 32.00
33.00	OTHER ADJUSTMENTS (SPECIFY (3))		0		0.00		0 33.00
34.00	MI SC. REVENUE	B	-12,399	OPERATION OF PLANT	7.00		0 34.00
35.02	MI SC. REVENUE	B	-11,704	HOUSEKEEPING	9.00		0 35.02
39.00	MI SC. REVENUE	B	-9,488	EMERGENCY	91.00		0 39.00
40.00	MI SC. REVENUE	B	-36,275	PHARMACY	15.00		0 40.00
41.01	MI SC. REVENUE	B	-263	DELIVERY ROOM & LABOR ROOM	52.00		0 41.01
42.00	MI SC. REVENUE	B	-60,624	RADIOLOGY - THERAPEUTIC	55.00		0 42.00
44.00	MI SC. REVENUE	B	-94,858	PHYSICAL THERAPY	66.00		0 44.00
44.01	MI SC. REVENUE	B	-2,516	RESPIRATORY THERAPY	65.00		0 44.01
44.02	MI SC. REVENUE	B	-12,681	CARDIAC REHABILITATION	69.01		0 44.02
44.03	MI SC. REVENUE	B	-3,774	CLINIC	90.00		0 44.03
45.00	MI SC. REVENUE	B	0		0.00		0 45.00
45.01	MI SC. REVENUE	B	-1,860	RADIOLOGY-DIAGNOSTIC	54.00		0 45.01
45.02	MI SC. REVENUE	B	-8,280	SPEECH PATHOLOGY	68.00		0 45.02
45.03	MI SC. REVENUE	B	-423	ELECTROCARDIOLOGY	69.00		0 45.03
45.04	GI FTS CONTRIBUTIONS & ENTERTAINMENT	A	-66,934	EMPLOYEE BENEFITS DEPARTMENT	4.00		0 45.04
45.05	GI FTS CONTRIBUTIONS & ENTERTAINMENT	A	-28,268	ADMINISTRATIVE & GENERAL	5.00		0 45.05
45.06	GI FTS CONTRIBUTIONS & ENTERTAINMENT	A	-106	OPERATION OF PLANT	7.00		0 45.06
45.07	GI FTS CONTRIBUTIONS & ENTERTAINMENT	A	-496	NURSING ADMINISTRATION	13.00		0 45.07
45.08	GI FTS CONTRIBUTIONS & ENTERTAINMENT	A	-50	MEDICAL RECORDS & LIBRARY	16.00		0 45.08
45.09	GI FTS CONTRIBUTIONS & ENTERTAINMENT	A	-44	DELIVERY ROOM & LABOR ROOM	52.00		0 45.09
45.10	GI FTS CONTRIBUTIONS & ENTERTAINMENT	A	-74	INTENSIVE CARE UNIT	31.00		0 45.10
45.11	GI FTS CONTRIBUTIONS & ENTERTAINMENT	A	-30	OPERATING ROOM	50.00		0 45.11
45.12	AMORTIZATION OF GOODWILL	A	0	CAP REL COSTS-MVBLE EQUIP	2.00		9 45.12
45.13	PATIENT TELEPHONE SERVICES	A	-25	CAP REL COSTS-BLDG & FIXT	1.00		9 45.13
45.15	PATIENT TELEPHONE SERVICE	A	-17,952	ADMINISTRATIVE & GENERAL	5.00		0 45.15
45.16	PATIENT TELEPHONE SERVICE	A	-16,775	ADMINISTRATIVE & GENERAL	5.00		0 45.16
45.17	PATIENT TELEPHONE SERVICE	A	-37	CAP REL COSTS-MVBLE EQUIP	2.00		9 45.17
45.18	PERSONAL USE (AUTO)		0		0.00		9 45.18
45.21	GI FTS CONTRIBUTIONS & ENTERTAINMENT		0	EMERGENCY	91.00		0 45.21
45.25	PHYSICIAN RECRUITMENT	A	-21,253	ADMINISTRATIVE & GENERAL	5.00		0 45.25
45.27	GI FTS CONTRIBUTIONS & ENTERTAINMENT		0	CLINIC	90.00		0 45.27
45.29	PATIENT TELEPHONE SERVICE		0		0.00		0 45.29
45.30	PATIENT TELEPHONE SERVICE BENEF	A	-5,234	EMPLOYEE BENEFITS DEPARTMENT	4.00		0 45.30
45.31	MEDICAL RECORDS BENEFITS		0	EMPLOYEE BENEFITS DEPARTMENT	4.00		0 45.31
45.32	PROF LAB INS DEDUCTIBLE RESERV	A	-274,000	ADMINISTRATIVE & GENERAL	5.00		0 45.32
45.40	WSI RENT EXPENSE	A	-49,593	PHYSICAL THERAPY	66.00		0 45.40
45.46	DUES RELATED TO LOBBYING EXP.	A	-3,879	ADMINISTRATIVE & GENERAL	5.00		0 45.46
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-17,519,662				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: 14-0034

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

Worksheet A-8-1

Date/Time Prepared:  
5/28/2019 11:34 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	117,387	0
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	575,815	0
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE INTEREST	0	764,609
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	6,778,136	11,989,501
4.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	7,204,042	11,256,246
4.02	7.00	OPERATION OF PLANT	HOME OFFICE	0	537,000
4.03	71.00	MEDICAL SUPPLIES CHARGED TO	HOME OFFICE	-81,419	0
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			14,593,961	24,547,356

\* 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>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>				

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

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

6.00	B	SSM HEALTH CARE	100.00	MOTHERHOUSE	100.00	6.00
7.00	B	SSM HEALTH STL	100.00	SSM	100.00	7.00
8.00	B	SSM HEALTH	100.00	FSI	100.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 14-0034

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

Worksheet A-8-1

Date/Time Prepared:  
5/28/2019 11:34 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	117,387	9		1.00
2.00	575,815	9		2.00
3.00	-764,609	11		3.00
4.00	-5,211,365	0		4.00
4.01	-4,052,204	0		4.01
4.02	-537,000	0		4.02
4.03	-81,419	0		4.03
5.00	-9,953,395			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>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>			

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	CONVENT		6.00
7.00	CORPORATE		7.00
8.00	CORPORATE		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: 14-0034

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

Worksheet A-8-2

Date/Time Prepared:  
5/28/2019 11:34 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	168,798	21,231	147,567	211,500	1,092	1.00
2.00	30.00	ADULTS & PEDIATRICS	664,195	664,195	0	179,000	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	5,119	5,119	0	211,500	0	3.00
4.00	40.00	SUBPROVIDER - IPF	14,000	14,000	0	181,300	0	4.00
5.00	50.00	OPERATING ROOM	34,800	34,800	0	197,500	0	5.00
6.00	53.00	ANESTHESIOLOGY	2,452,307	2,452,307	0	239,400	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	208,333	208,333	0	271,900	0	7.00
8.00	55.00	RADIOLOGY - THERAPEUTIC	592,988	47,339	545,649	271,900	2,240	8.00
9.00	56.00	RADIOISOTOPE	23,924	23,924	0	271,900	0	9.00
10.00	60.00	LABORATORY	415,297	7,932	407,365	260,300	4,074	10.00
11.00	65.00	RESPIRATORY THERAPY	54,701	44,501	10,200	197,500	102	11.00
12.00	67.00	OCCUPATIONAL THERAPY	0	0	0	197,500	0	12.00
13.00	69.00	ELECTROCARDIOLOGY	322,034	322,034	0	197,500	0	13.00
14.00	69.01	CARDIAC REHABILITATION	0	0	0	197,500	0	14.00
15.00	70.00	ELECTROENCEPHALOGRAPHY	210,364	200,164	10,200	197,500	102	15.00
16.00	76.00	ENDOSCOPY	32,900	0	32,900	197,500	208	16.00
17.00	90.00	CLINIC	234,788	229,108	5,680	179,000	45	17.00
18.00	91.00	EMERGENCY	1,229,089	1,229,089	0	179,000	0	18.00
200.00			6,663,637	5,504,076	1,159,561		7,863	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	111,038	5,552	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	7.00
8.00	55.00	RADIOLOGY - THERAPEUTIC	292,815	14,641	0	0	0	8.00
9.00	56.00	RADIOISOTOPE	0	0	0	0	0	9.00
10.00	60.00	LABORATORY	509,838	25,492	0	0	0	10.00
11.00	65.00	RESPIRATORY THERAPY	9,685	484	0	0	0	11.00
12.00	67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	12.00
13.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	13.00
14.00	69.01	CARDIAC REHABILITATION	0	0	0	0	0	14.00
15.00	70.00	ELECTROENCEPHALOGRAPHY	9,685	484	0	0	0	15.00
16.00	76.00	ENDOSCOPY	19,750	988	0	0	0	16.00
17.00	90.00	CLINIC	3,873	194	0	0	0	17.00
18.00	91.00	EMERGENCY	0	0	0	0	0	18.00
200.00			956,684	47,835	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	111,038	36,529	57,760		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	664,195		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	5,119		3.00
4.00	40.00	SUBPROVIDER - IPF	0	0	0	14,000		4.00
5.00	50.00	OPERATING ROOM	0	0	0	34,800		5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	2,452,307		6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	208,333		7.00
8.00	55.00	RADIOLOGY - THERAPEUTIC	0	292,815	252,834	300,173		8.00
9.00	56.00	RADIOISOTOPE	0	0	0	23,924		9.00
10.00	60.00	LABORATORY	0	509,838	0	7,932		10.00
11.00	65.00	RESPIRATORY THERAPY	0	9,685	515	45,016		11.00
12.00	67.00	OCCUPATIONAL THERAPY	0	0	0	0		12.00
13.00	69.00	ELECTROCARDIOLOGY	0	0	0	322,034		13.00
14.00	69.01	CARDIAC REHABILITATION	0	0	0	0		14.00
15.00	70.00	ELECTROENCEPHALOGRAPHY	0	9,685	515	200,679		15.00
16.00	76.00	ENDOSCOPY	0	19,750	13,150	13,150		16.00
17.00	90.00	CLINIC	0	3,873	1,807	230,915		17.00
18.00	91.00	EMERGENCY	0	0	0	1,229,089		18.00
200.00			0	956,684	305,350	5,809,426		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0034

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/28/2019 11:34 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	3,735,685	3,735,685			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	2,172,101		2,172,101		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	8,950,663	21,005	412	8,972,080	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	15,058,364	1,206,352	93,170	810,944	17,168,830
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00 00700	OPERATION OF PLANT	4,042,016	290,918	840,043	178,408	5,351,385
8.00 00800	LAUNDRY & LINEN SERVICE	397,279	84,073	779	26,845	508,976
9.00 00900	HOUSEKEEPING	1,193,871	50,740	3,169	264,505	1,512,285
10.00 01000	DIETARY	406,993	28,470	19,300	59,768	514,531
11.00 01100	CAFETERIA	704,316	72,992	0	142,959	920,267
13.00 01300	NURSING ADMINISTRATION	1,032,164	7,178	73,406	250,365	1,363,113
14.00 01400	CENTRAL SERVICE & SUPPLY	261,392	6,281	4,647	32,157	304,477
15.00 01500	PHARMACY	1,300,957	0	1,996	288,510	1,591,463
16.00 01600	MEDICAL RECORDS & LIBRARY	724,337	43,382	1,482	153,617	922,818
17.00 01700	SOCIAL SERVICE	1,040,027	18,035	0	201,641	1,259,703
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	6,128,223	491,114	57,171	1,612,811	8,289,319
31.00 03100	INTENSIVE CARE UNIT	1,907,495	52,032	60,741	378,906	2,399,174
40.00 04000	SUBPROVIDER - IPF	1,995,562	64,279	14,246	525,221	2,599,308
43.00 04300	NURSERY	165,882	34,903	3,740	38,292	242,817
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	2,204,778	410,038	163,411	383,433	3,161,660
51.00 05100	RECOVERY ROOM	307,631	0	0	81,205	388,836
52.00 05200	DELIVERY ROOM & LABOR ROOM	749,800	59,237	18,903	406,072	1,234,012
53.00 05300	ANESTHESIOLOGY	325,958	3,733	17,116	59,264	406,071
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,021,415	114,732	109,421	257,457	1,503,025
55.00 05500	RADIOLOGY - THERAPEUTIC	985,464	0	165,161	262,672	1,413,297
56.00 05600	RADIOISOTOPE	451,413	8,470	9,171	44,720	513,774
57.00 05700	CT SCAN	382,862	2,100	59,977	91,163	536,102
58.00 05800	MRI	152,713	3,661	105,934	37,072	299,380
59.00 05900	CARDIAC CATHETERIZATION	217,508	22,360	34,448	57,281	331,597
60.00 06000	LABORATORY	3,949,552	16,249	28,540	430,578	4,424,919
64.00 06400	INTRAVENOUS THERAPY	235,232	9,520	252	59,203	304,207
65.00 06500	RESPIRATORY THERAPY	1,202,696	11,225	11,122	288,609	1,513,652
66.00 06600	PHYSICAL THERAPY	1,200,332	42,718	5,330	278,596	1,526,976
66.01 06601	CLINICAL NUTRITION	173,278	0	0	45,678	218,956
67.00 06700	OCCUPATIONAL THERAPY	140,129	0	0	36,463	176,592
68.00 06800	SPEECH PATHOLOGY	99,303	6,487	0	27,135	132,925
69.00 06900	ELECTROCARDIOLOGY	744,220	53,826	49,204	164,588	1,011,838
69.01 06901	CARDIAC REHABILITATION	68,386	0	1,193	21,402	90,981
70.00 07000	ELECTROENCEPHALOGRAPHY	105,995	0	3,585	26,485	136,065
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	3,393,364	0	0	0	3,393,364
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	820,802	0	0	0	820,802
73.00 07300	DRUGS CHARGED TO PATIENTS	3,486,982	0	0	0	3,486,982
74.00 07400	RENAL DIALYSIS	154,464	0	0	0	154,464
76.00 03330	ENDOSCOPY	148,820	0	2,010	39,276	190,106
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	1,803,126	3,553	21,690	353,436	2,181,805
91.00 09100	EMERGENCY	2,029,305	53,369	23,890	514,891	2,621,455
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)					0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 09910	CORF	0	0	0	0	0
99.20 09920	OPT	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	77,772,855	3,293,032	2,004,660	8,931,628	77,122,309
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	35,020	2,943	0	8,853	46,816
192.00 19200	PHYSICIANS' PRIVATE OFFICES	-42,376	0	158,286	0	115,910
194.00 07950	NONREIMBURSABLE	234,475	439,710	9,155	31,599	714,939
194.01 07951	RETAIL PHARMACY	148,768	0	0	0	148,768
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	78,148,742	3,735,685	2,172,101	8,972,080	78,148,742

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part I Date/Time Prepared: 5/28/2019 11:34 am				
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
		5.00	6.00	7.00	8.00	9.00		
<b>GENERAL SERVICE COST CENTERS</b>								
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	17,168,830			5.00		
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00		
7.00	00700	OPERATION OF PLANT	1,506,677	0	6,858,062	7.00		
8.00	00800	LAUNDRY & LINEN SERVICE	143,302	0	260,023	912,301	8.00	
9.00	00900	HOUSEKEEPING	425,782	0	156,930	122,285	2,217,282	9.00
10.00	01000	DIETARY	144,866	0	88,053	1,935	1,061	10.00
11.00	01100	CAFETERIA	259,100	0	225,751	4,629	2,475	11.00
13.00	01300	NURSING ADMINISTRATION	383,783	0	22,200	0	3,889	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	85,725	0	19,425	0	3,182	14.00
15.00	01500	PHARMACY	448,075	0	0	0	26,518	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	259,818	0	134,174	0	11,668	16.00
17.00	01700	SOCIAL SERVICE	354,668	0	55,779	0	7,425	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	2,333,848	0	1,518,929	233,852	571,733	30.00
31.00	03100	INTENSIVE CARE UNIT	675,485	0	160,926	49,482	117,034	31.00
40.00	04000	SUBPROVIDER - IPF	731,833	0	198,805	36,585	115,620	40.00
43.00	04300	NURSERY	68,365	0	107,950	3,969	12,375	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	890,162	0	1,268,175	96,950	295,944	50.00
51.00	05100	RECOVERY ROOM	109,476	0	0	0	23,690	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	347,435	0	183,209	35,284	10,961	52.00
53.00	05300	ANESTHESIOLOGY	114,329	0	11,544	0	25,811	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	423,175	0	354,847	87,059	12,729	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	397,912	0	0	7,186	10,961	55.00
56.00	05600	RADIOISOTOPE	144,653	0	26,197	0	4,243	56.00
57.00	05700	CT SCAN	150,939	0	6,494	0	0	57.00
58.00	05800	MRI	84,290	0	11,322	0	3,536	58.00
59.00	05900	CARDIAC CATHETERIZATION	93,361	0	69,155	3,916	26,165	59.00
60.00	06000	LABORATORY	1,245,832	0	50,256	0	48,086	60.00
64.00	06400	INTRAVENOUS THERAPY	85,649	0	29,443	3,742	21,568	64.00
65.00	06500	RESPIRATORY THERAPY	426,167	0	34,716	0	27,579	65.00
66.00	06600	PHYSICAL THERAPY	429,919	0	132,121	47,356	122,691	66.00
66.01	06601	CLINICAL NUTRITION	61,647	0	0	0	1,768	66.01
67.00	06700	OCCUPATIONAL THERAPY	49,719	0	0	0	9,900	67.00
68.00	06800	SPEECH PATHOLOGY	37,425	0	20,064	0	2,829	68.00
69.00	06900	ELECTROCARDIOLOGY	284,882	0	166,476	16,148	25,811	69.00
69.01	06901	CARDIAC REHABILITATION	25,616	0	0	0	7,072	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	38,309	0	0	3,945	6,718	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	955,398	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	231,096	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	981,756	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	43,489	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	53,524	0	0	0	21,215	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	614,285	0	10,989	8,042	260,233	90.00
91.00	09100	EMERGENCY	738,068	0	165,061	145,665	206,843	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	0	99.20
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,879,840	0	5,489,014	908,030	2,049,333	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	13,181	0	9,102	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	32,634	0	0	4,271	141,784	192.00
194.00	07950	NONREIMBURSABLE	201,290	0	1,359,946	0	26,165	194.00
194.01	07951	RETAIL PHARMACY	41,885	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	17,168,830	0	6,858,062	912,301	2,217,282	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 14-0034		Period: From 01/01/2018 To 12/31/2018		Worksheet B Part I Date/Time Prepared: 5/28/2019 11:34 am	
Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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	750,446					10.00
11.00	01100	0	1,412,222				11.00
13.00	01300	0	37,743	1,810,728			13.00
14.00	01400	0	6,291	7,878	426,978		14.00
15.00	01500	0	44,034	58,708	0	2,168,798	15.00
16.00	01600	0	40,888	53,665	0	0	16.00
17.00	01700	0	34,598	47,577	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	468,649	314,522	412,697	0	0	30.00
31.00	03100	39,825	75,486	97,798	0	0	31.00
40.00	04000	165,615	106,939	140,472	0	0	40.00
43.00	04300	0	6,291	8,698	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	3,477	94,358	124,784	0	0	50.00
51.00	05100	0	12,581	17,721	0	0	51.00
52.00	05200	0	34,598	43,960	0	0	52.00
53.00	05300	0	3,145	5,019	0	0	53.00
54.00	05400	0	53,469	71,175	0	0	54.00
55.00	05500	14,953	25,162	31,577	0	0	55.00
56.00	05600	0	6,291	9,160	0	0	56.00
57.00	05700	0	25,162	34,702	0	0	57.00
58.00	05800	0	6,291	9,009	0	0	58.00
59.00	05900	1,773	6,291	10,014	0	0	59.00
60.00	06000	0	103,794	134,896	0	0	60.00
64.00	06400	1,963	12,581	15,463	0	0	64.00
65.00	06500	0	59,760	77,157	0	0	65.00
66.00	06600	0	50,324	65,791	0	0	66.00
66.01	06601	0	9,436	13,709	0	0	66.01
67.00	06700	0	6,291	6,765	0	0	67.00
68.00	06800	0	6,291	6,701	0	0	68.00
69.00	06900	3,970	31,453	43,136	0	0	69.00
69.01	06901	0	3,145	5,911	0	0	69.01
70.00	07000	1,764	6,291	7,394	0	0	70.00
71.00	07100	0	0	0	426,978	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	2,168,798	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03330	4,774	6,291	8,308	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	917	75,486	99,984	0	0	90.00
91.00	09100	42,766	97,503	128,891	0	0	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	0	0	0	0	0	99.10
99.20	09920	0	0	0	0	0	99.20
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00							
	SUBTOTALS (SUM OF LINES 1 through 117)	750,446	1,402,786	1,798,720	426,978	2,168,798	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	3,145	4,250	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	6,291	7,758	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	750,446	1,412,222	1,810,728	426,978	2,168,798	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0034

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/28/2019 11:34 am

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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 SERVICE & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,423,031				16.00
17.00	01700	SOCIAL SERVICE	0	1,759,750			17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	85,382	1,126,240	15,355,171	0	15,355,171
31.00	03100	INTENSIVE CARE UNIT	14,230	140,780	3,770,220	0	3,770,220
40.00	04000	SUBPROVIDER - IPF	28,461	457,535	4,581,173	0	4,581,173
43.00	04300	NURSERY	0	35,195	485,660	0	485,660
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	142,303	0	6,077,813	0	6,077,813
51.00	05100	RECOVERY ROOM	14,230	0	566,534	0	566,534
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,230	0	1,903,689	0	1,903,689
53.00	05300	ANESTHESIOLOGY	28,461	0	594,380	0	594,380
54.00	05400	RADIOLOGY-DIAGNOSTIC	71,152	0	2,576,631	0	2,576,631
55.00	05500	RADIOLOGY - THERAPEUTIC	42,691	0	1,943,739	0	1,943,739
56.00	05600	RADIOISOTOPE	28,461	0	732,779	0	732,779
57.00	05700	CT SCAN	156,533	0	909,932	0	909,932
58.00	05800	MRI	28,461	0	442,289	0	442,289
59.00	05900	CARDIAC CATHETERIZATION	14,230	0	556,502	0	556,502
60.00	06000	LABORATORY	241,914	0	6,249,697	0	6,249,697
64.00	06400	INTRAVENOUS THERAPY	14,230	0	488,846	0	488,846
65.00	06500	RESPIRATORY THERAPY	56,921	0	2,195,952	0	2,195,952
66.00	06600	PHYSICAL THERAPY	28,461	0	2,403,639	0	2,403,639
66.01	06601	CLINICAL NUTRITION	0	0	305,516	0	305,516
67.00	06700	OCCUPATIONAL THERAPY	0	0	249,267	0	249,267
68.00	06800	SPEECH PATHOLOGY	0	0	206,235	0	206,235
69.00	06900	ELECTROCARDIOLOGY	71,152	0	1,654,866	0	1,654,866
69.01	06901	CARDIAC REHABILITATION	0	0	132,725	0	132,725
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	200,486	0	200,486
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	14,230	0	4,789,970	0	4,789,970
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	14,230	0	1,066,128	0	1,066,128
73.00	07300	DRUGS CHARGED TO PATIENTS	128,073	0	6,765,609	0	6,765,609
74.00	07400	RENAL DIALYSIS	0	0	197,953	0	197,953
76.00	03330	ENDOSCOPY	28,461	0	312,679	0	312,679
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	28,461	0	3,280,202	0	3,280,202
91.00	09100	EMERGENCY	128,073	0	4,274,325	0	4,274,325
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)				0	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	99.20
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,423,031	1,759,750	75,270,607	0	75,270,607
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	76,494	0	76,494
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	294,599	0	294,599
194.00	07950	NONREIMBURSABLE	0	0	2,316,389	0	2,316,389
194.01	07951	RETAIL PHARMACY	0	0	190,653	0	190,653
200.00		Cross Foot Adjustments			0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,423,031	1,759,750	78,148,742	0	78,148,742

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part II Date/Time Prepared: 5/28/2019 11:34 am
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Line	Code	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
				1.00	2.00			
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	21,005	412	21,417	21,417	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	649,601	1,206,352	93,170	1,949,123	1,937	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	532	290,918	840,043	1,131,493	426	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	84,073	779	84,852	64	8.00
9.00	00900	HOUSEKEEPING	0	50,740	3,169	53,909	632	9.00
10.00	01000	DIETARY	0	28,470	19,300	47,770	143	10.00
11.00	01100	CAFETERIA	0	72,992	0	72,992	341	11.00
13.00	01300	NURSING ADMINISTRATION	0	7,178	73,406	80,584	598	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	69,960	6,281	4,647	80,888	77	14.00
15.00	01500	PHARMACY	0	0	1,996	1,996	689	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	43,382	1,482	44,864	367	16.00
17.00	01700	SOCIAL SERVICE	0	18,035	0	18,035	482	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	38,637	491,114	57,171	586,922	3,841	30.00
31.00	03100	INTENSIVE CARE UNIT	1,126	52,032	60,741	113,899	905	31.00
40.00	04000	SUBPROVIDER - IPF	0	64,279	14,246	78,525	1,254	40.00
43.00	04300	NURSERY	0	34,903	3,740	38,643	91	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	356	410,038	163,411	573,805	916	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	194	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	59,237	18,903	78,140	970	52.00
53.00	05300	ANESTHESIOLOGY	73	3,733	17,116	20,922	142	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	114,732	109,421	224,153	615	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	165,161	165,161	627	55.00
56.00	05600	RADIOISOTOPE	0	8,470	9,171	17,641	107	56.00
57.00	05700	CT SCAN	0	2,100	59,977	62,077	218	57.00
58.00	05800	MRI	8,389	3,661	105,934	117,984	89	58.00
59.00	05900	CARDIAC CATHETERIZATION	7	22,360	34,448	56,815	137	59.00
60.00	06000	LABORATORY	7	16,249	28,540	44,796	1,028	60.00
64.00	06400	INTRAVENOUS THERAPY	0	9,520	252	9,772	141	64.00
65.00	06500	RESPIRATORY THERAPY	16,309	11,225	11,122	38,656	689	65.00
66.00	06600	PHYSICAL THERAPY	77,600	42,718	5,330	125,648	665	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	0	109	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	87	67.00
68.00	06800	SPEECH PATHOLOGY	14,790	6,487	0	21,277	65	68.00
69.00	06900	ELECTROCARDIOLOGY	113	53,826	49,204	103,143	393	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	1,193	1,193	51	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	3,585	3,585	63	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	51	0	2,010	2,061	94	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	37,412	3,553	21,690	62,655	844	90.00
91.00	09100	EMERGENCY	0	53,369	23,890	77,259	1,230	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)				0		92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	0	99.20
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	914,963	3,293,032	2,004,660	6,212,655	21,321	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	2,943	0	2,943	21	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-49,593	0	158,286	108,693	0	192.00
194.00	07950	NONREIMBURSABLE	0	439,710	9,155	448,865	75	194.00
194.01	07951	RETAIL PHARMACY	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	865,370	3,735,685	2,172,101	6,773,156	21,417	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part II Date/Time Prepared: 5/28/2019 11:34 am				
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
		5.00	6.00	7.00	8.00	9.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00		
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00		
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00		
5.00	00500	ADMINISTRATIVE & GENERAL	1,951,060			5.00		
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00		
7.00	00700	OPERATION OF PLANT	171,218	0	1,303,137	7.00		
8.00	00800	LAUNDRY & LINEN SERVICE	16,285	0	49,408	150,609	8.00	
9.00	00900	HOUSEKEEPING	48,386	0	29,819	20,188	152,934	9.00
10.00	01000	DIETARY	16,462	0	16,731	319	73	10.00
11.00	01100	CAFETERIA	29,444	0	42,896	764	171	11.00
13.00	01300	NURSING ADMINISTRATION	43,613	0	4,218	0	268	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	9,742	0	3,691	0	219	14.00
15.00	01500	PHARMACY	50,919	0	0	0	1,829	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	29,526	0	25,495	0	805	16.00
17.00	01700	SOCIAL SERVICE	40,304	0	10,599	0	512	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	265,224	0	288,621	38,607	39,435	30.00
31.00	03100	INTENSIVE CARE UNIT	76,762	0	30,578	8,169	8,072	31.00
40.00	04000	SUBPROVIDER - IPF	83,165	0	37,776	6,040	7,975	40.00
43.00	04300	NURSERY	7,769	0	20,512	655	854	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	101,157	0	240,973	16,005	20,412	50.00
51.00	05100	RECOVERY ROOM	12,441	0	0	0	1,634	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	39,482	0	34,813	5,825	756	52.00
53.00	05300	ANESTHESIOLOGY	12,992	0	2,194	0	1,780	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	48,089	0	67,426	14,372	878	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	45,218	0	0	1,186	756	55.00
56.00	05600	RADIOISOTOPE	16,438	0	4,978	0	293	56.00
57.00	05700	CT SCAN	17,153	0	1,234	0	0	57.00
58.00	05800	MRI	9,579	0	2,151	0	244	58.00
59.00	05900	CARDIAC CATHETERIZATION	10,609	0	13,140	646	1,805	59.00
60.00	06000	LABORATORY	141,575	0	9,549	0	3,317	60.00
64.00	06400	INTRAVENOUS THERAPY	9,733	0	5,595	618	1,488	64.00
65.00	06500	RESPIRATORY THERAPY	48,429	0	6,597	0	1,902	65.00
66.00	06600	PHYSICAL THERAPY	48,856	0	25,105	7,818	8,462	66.00
66.01	06601	CLINICAL NUTRITION	7,005	0	0	0	122	66.01
67.00	06700	OCCUPATIONAL THERAPY	5,650	0	0	0	683	67.00
68.00	06800	SPEECH PATHOLOGY	4,253	0	3,812	0	195	68.00
69.00	06900	ELECTROCARDIOLOGY	32,374	0	31,633	2,666	1,780	69.00
69.01	06901	CARDIAC REHABILITATION	2,911	0	0	0	488	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	4,353	0	0	651	463	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	108,571	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	26,262	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	111,566	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	4,942	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	6,082	0	0	0	1,463	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	69,807	0	2,088	1,328	17,949	90.00
91.00	09100	EMERGENCY	83,873	0	31,364	24,047	14,267	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	0	99.20
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,918,219	0	1,042,996	149,904	141,350	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	1,498	0	1,730	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,709	0	0	705	9,779	192.00
194.00	07950	NONREIMBURSABLE	22,874	0	258,411	0	1,805	194.00
194.01	07951	RETAIL PHARMACY	4,760	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,951,060	0	1,303,137	150,609	152,934	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0034

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/28/2019 11:34 am

	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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	81,498					10.00
11.00	01100	0	146,608				11.00
13.00	01300	0	3,918	133,199			13.00
14.00	01400	0	653	579	95,849		14.00
15.00	01500	0	4,571	4,319	0	64,323	15.00
16.00	01600	0	4,245	3,948	0	0	16.00
17.00	01700	0	3,592	3,500	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	50,894	32,650	30,356	0	0	30.00
31.00	03100	4,325	7,837	7,194	0	0	31.00
40.00	04000	17,986	11,102	10,333	0	0	40.00
43.00	04300	0	653	640	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	378	9,796	9,179	0	0	50.00
51.00	05100	0	1,306	1,304	0	0	51.00
52.00	05200	0	3,592	3,234	0	0	52.00
53.00	05300	0	327	369	0	0	53.00
54.00	05400	0	5,551	5,236	0	0	54.00
55.00	05500	1,624	2,612	2,323	0	0	55.00
56.00	05600	0	653	674	0	0	56.00
57.00	05700	0	2,612	2,553	0	0	57.00
58.00	05800	0	653	663	0	0	58.00
59.00	05900	193	653	737	0	0	59.00
60.00	06000	0	10,775	9,923	0	0	60.00
64.00	06400	213	1,306	1,137	0	0	64.00
65.00	06500	0	6,204	5,676	0	0	65.00
66.00	06600	0	5,224	4,840	0	0	66.00
66.01	06601	0	980	1,008	0	0	66.01
67.00	06700	0	653	498	0	0	67.00
68.00	06800	0	653	493	0	0	68.00
69.00	06900	431	3,265	3,173	0	0	69.00
69.01	06901	0	327	435	0	0	69.01
70.00	07000	192	653	544	0	0	70.00
71.00	07100	0	0	0	95,849	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	64,323	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03330	518	653	611	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	100	7,837	7,355	0	0	90.00
91.00	09100	4,644	10,122	9,481	0	0	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	0	0	0	0	0	99.10
99.20	09920	0	0	0	0	0	99.20
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00							
	SUBTOTALS (SUM OF LINES 1 through 117)	81,498	145,628	132,315	95,849	64,323	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	327	313	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	653	571	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	81,498	146,608	133,199	95,849	64,323	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0034		Period: From 01/01/2018 To 12/31/2018		Worksheet B Part II Date/Time Prepared: 5/28/2019 11:34 am	
Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>								
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 SERVICE & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	109,250					16.00
17.00	01700	SOCIAL SERVICE	0	77,024				17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	6,555	49,296	1,392,401	0	1,392,401	30.00
31.00	03100	INTENSIVE CARE UNIT	1,093	6,162	264,996	0	264,996	31.00
40.00	04000	SUBPROVIDER - IPF	2,185	20,026	276,367	0	276,367	40.00
43.00	04300	NURSERY	0	1,540	71,357	0	71,357	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	10,925	0	983,546	0	983,546	50.00
51.00	05100	RECOVERY ROOM	1,093	0	17,972	0	17,972	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,093	0	167,905	0	167,905	52.00
53.00	05300	ANESTHESIOLOGY	2,185	0	40,911	0	40,911	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,463	0	371,783	0	371,783	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	3,278	0	222,785	0	222,785	55.00
56.00	05600	RADIOISOTOPE	2,185	0	42,969	0	42,969	56.00
57.00	05700	CT SCAN	12,018	0	97,865	0	97,865	57.00
58.00	05800	MRI	2,185	0	133,548	0	133,548	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,093	0	85,828	0	85,828	59.00
60.00	06000	LABORATORY	18,566	0	239,529	0	239,529	60.00
64.00	06400	INTRAVENOUS THERAPY	1,093	0	31,096	0	31,096	64.00
65.00	06500	RESPIRATORY THERAPY	4,370	0	112,523	0	112,523	65.00
66.00	06600	PHYSICAL THERAPY	2,185	0	228,803	0	228,803	66.00
66.01	06601	CLINICAL NUTRITION	0	0	9,224	0	9,224	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	7,571	0	7,571	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	30,748	0	30,748	68.00
69.00	06900	ELECTROCARDIOLOGY	5,463	0	184,321	0	184,321	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	5,405	0	5,405	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	10,504	0	10,504	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1,093	0	205,513	0	205,513	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	1,093	0	27,355	0	27,355	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,833	0	185,722	0	185,722	73.00
74.00	07400	RENAL DIALYSIS	0	0	4,942	0	4,942	74.00
76.00	03330	ENDOSCOPY	2,185	0	13,667	0	13,667	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	2,185	0	172,148	0	172,148	90.00
91.00	09100	EMERGENCY	9,833	0	266,120	0	266,120	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)				0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	0	99.20
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	109,250	77,024	5,905,424	0	5,905,424	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	6,832	0	6,832	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	122,886	0	122,886	192.00
194.00	07950	NONREIMBURSABLE	0	0	733,254	0	733,254	194.00
194.01	07951	RETAIL PHARMACY	0	0	4,760	0	4,760	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	109,250	77,024	6,773,156	0	6,773,156	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0034

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

Worksheet B-1

Date/Time Prepared:  
5/28/2019 11:34 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00	4.00				
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	CAP REL COSTS-BLDG & FIXT	416,345					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		4,328,849				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,341	822	33,744,343			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	134,449	185,681	3,049,993	-17,168,830	60,979,912	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	32,423	1,674,148	670,998	0	5,351,385	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	9,370	1,552	100,964	0	508,976	8.00
9.00 00900	HOUSEKEEPING	5,655	6,316	994,815	0	1,512,285	9.00
10.00 01000	DIETARY	3,173	38,463	224,791	0	514,531	10.00
11.00 01100	CAFETERIA	8,135	0	537,675	0	920,267	11.00
13.00 01300	NURSING ADMINISTRATION	800	146,294	941,632	0	1,363,113	13.00
14.00 01400	CENTRAL SERVICE & SUPPLY	700	9,262	120,944	0	304,477	14.00
15.00 01500	PHARMACY	0	3,977	1,085,099	0	1,591,463	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	4,835	2,953	577,761	0	922,818	16.00
17.00 01700	SOCIAL SERVICE	2,010	0	758,381	0	1,259,703	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	54,735	113,937	6,065,843	0	8,289,319	30.00
31.00 03100	INTENSIVE CARE UNIT	5,799	121,052	1,425,080	0	2,399,174	31.00
40.00 04000	SUBPROVIDER - IPF	7,164	28,391	1,975,377	0	2,599,308	40.00
43.00 04300	NURSERY	3,890	7,453	144,019	0	242,817	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	45,699	325,667	1,442,106	0	3,161,660	50.00
51.00 05100	RECOVERY ROOM	0	0	305,416	0	388,836	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	6,602	37,673	1,527,253	0	1,234,012	52.00
53.00 05300	ANESTHESIOLOGY	416	34,112	222,895	0	406,071	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	12,787	218,069	968,306	0	1,503,025	54.00
55.00 05500	RADIOLOGY - THERAPEUTIC	0	329,154	987,918	0	1,413,297	55.00
56.00 05600	RADIOISOTOPE	944	18,278	168,193	0	513,774	56.00
57.00 05700	CT SCAN	234	119,530	342,866	0	536,102	57.00
58.00 05800	MRI	408	211,119	139,429	0	299,380	58.00
59.00 05900	CARDIAC CATHETERIZATION	2,492	68,652	215,435	0	331,597	59.00
60.00 06000	LABORATORY	1,811	56,879	1,619,419	0	4,424,919	60.00
64.00 06400	INTRAVENOUS THERAPY	1,061	502	222,665	0	304,207	64.00
65.00 06500	RESPIRATORY THERAPY	1,251	22,165	1,085,471	0	1,513,652	65.00
66.00 06600	PHYSICAL THERAPY	4,761	10,623	1,047,811	0	1,526,976	66.00
66.01 06601	CLINICAL NUTRITION	0	0	171,797	0	218,956	66.01
67.00 06700	OCCUPATIONAL THERAPY	0	0	137,139	0	176,592	67.00
68.00 06800	SPEECH PATHOLOGY	723	0	102,057	0	132,925	68.00
69.00 06900	ELECTROCARDIOLOGY	5,999	98,061	619,021	0	1,011,838	69.00
69.01 06901	CARDIAC REHABILITATION	0	2,377	80,495	0	90,981	69.01
70.00 07000	ELECTROENCEPHALOGRAPHY	0	7,144	99,610	0	136,065	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	3,393,364	71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	820,802	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,486,982	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	154,464	74.00
76.00 03330	ENDOSCOPY	0	4,005	147,717	0	190,106	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000	CLINIC	396	43,227	1,329,286	0	2,181,805	90.00
91.00 09100	EMERGENCY	5,948	47,611	1,936,526	0	2,621,455	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10 09910	CORF	0	0	0	0	0	99.10
99.20 09920	OPT	0	0	0	0	0	99.20
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	367,011	3,995,149	33,592,203	-17,168,830	59,953,479	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	328	0	33,295	0	46,816	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	315,454	0	0	115,910	192.00
194.00 07950	NONREIMBURSABLE	49,006	18,246	118,845	0	714,939	194.00
194.01 07951	RETAIL PHARMACY	0	0	0	0	148,768	194.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	3,735,685	2,172,101	8,972,080		17,168,830	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	8.972571	0.501773	0.265884		0.281549	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			21,417		1,951,060	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0034

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

Worksheet B-1  
Date/Time Prepared:  
5/28/2019 11:34 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00				
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000635		0.031995	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: 14-0034

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

Worksheet B-1

Date/Time Prepared:  
5/28/2019 11:34 am

Cost Center Description		MAINTENANCE & REPAIRS (HOURS OF SERVICE)	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	
<b>GENERAL SERVICE COST CENTERS</b>							
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	3,597				6.00
7.00	00700	OPERATION OF PLANT	0	247,132			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	9,370	535,136		8.00
9.00	00900	HOUSEKEEPING	0	5,655	71,730	6,271	9.00
10.00	01000	DIETARY	0	3,173	1,135	3	86,774
11.00	01100	CAFETERIA	0	8,135	2,715	7	0
13.00	01300	NURSING ADMINISTRATION	149	800	0	11	0
14.00	01400	CENTRAL SERVICE & SUPPLY	349	700	0	9	0
15.00	01500	PHARMACY	0	0	0	75	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,835	0	33	0
17.00	01700	SOCIAL SERVICE	0	2,010	0	21	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	282	54,735	137,173	1,617	54,190
31.00	03100	INTENSIVE CARE UNIT	107	5,799	29,025	331	4,605
40.00	04000	SUBPROVIDER - IPF	4	7,164	21,460	327	19,150
43.00	04300	NURSERY	0	3,890	2,328	35	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	535	45,699	56,869	837	402
51.00	05100	RECOVERY ROOM	0	0	0	67	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,602	20,697	31	0
53.00	05300	ANESTHESIOLOGY	154	416	0	73	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	454	12,787	51,067	36	0
55.00	05500	RADIOLOGY - THERAPEUTIC	41	0	4,215	31	1,729
56.00	05600	RADIOISOTOPE	41	944	0	12	0
57.00	05700	CT SCAN	424	234	0	0	0
58.00	05800	MRI	50	408	0	10	0
59.00	05900	CARDIAC CATHETERIZATION	51	2,492	2,297	74	205
60.00	06000	LABORATORY	96	1,811	0	136	0
64.00	06400	INTRAVENOUS THERAPY	0	1,061	2,195	61	227
65.00	06500	RESPIRATORY THERAPY	378	1,251	0	78	0
66.00	06600	PHYSICAL THERAPY	18	4,761	27,778	347	0
66.01	06601	CLINICAL NUTRITION	0	0	0	5	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	28	0
68.00	06800	SPEECH PATHOLOGY	0	723	0	8	0
69.00	06900	ELECTROCARDIOLOGY	130	5,999	9,472	73	459
69.01	06901	CARDIAC REHABILITATION	6	0	0	20	0
70.00	07000	ELECTROENCEPHALOGRAPHY	105	0	2,314	19	204
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
76.00	03330	ENDOSCOPY	56	0	0	60	552
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	35	396	4,717	736	106
91.00	09100	EMERGENCY	132	5,948	85,444	585	4,945
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)					
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0	0	0
99.20	09920	OPT	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,597	197,798	532,631	5,796	86,774
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	328	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	2,505	401	0
194.00	07950	NONREIMBURSABLE	0	49,006	0	74	0
194.01	07951	RETAIL PHARMACY	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)	0	6,858,062	912,301	2,217,282	750,446
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	27.750603	1.704802	353.577101	8.648282
204.00		Cost to be allocated (per Wkst. B, Part II)	0	1,303,137	150,609	152,934	81,498
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	5.273040	0.281441	24.387498	0.939198

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0034

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

Worksheet B-1

Date/Time Prepared:  
5/28/2019 11:34 am

Cost Center Description		MAINTENANCE & REPAIRS (HOURS OF SERVICE)	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: 14-0034

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

Worksheet B-1  
Date/Time Prepared:  
5/28/2019 11:34 am

Cost Center Description		CAFETERIA (FULL TIME EQUIVALENT)	NURSING ADMINISTRATION (FULL TIME EQUIVALENT)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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	449					11.00
13.00	01300	12	909,528				13.00
14.00	01400	2	3,957	3,474,783			14.00
15.00	01500	14	29,489	0	1,923,837		15.00
16.00	01600	13	26,956	0	0	100	16.00
17.00	01700	11	23,898	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	100	207,298	0	0	6	30.00
31.00	03100	24	49,124	0	0	1	31.00
40.00	04000	34	70,559	0	0	2	40.00
43.00	04300	2	4,369	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	30	62,679	0	0	10	50.00
51.00	05100	4	8,901	0	0	1	51.00
52.00	05200	11	22,081	0	0	1	52.00
53.00	05300	1	2,521	0	0	2	53.00
54.00	05400	17	35,751	0	0	5	54.00
55.00	05500	8	15,861	0	0	3	55.00
56.00	05600	2	4,601	0	0	2	56.00
57.00	05700	8	17,431	0	0	11	57.00
58.00	05800	2	4,525	0	0	2	58.00
59.00	05900	2	5,030	0	0	1	59.00
60.00	06000	33	67,758	0	0	17	60.00
64.00	06400	4	7,767	0	0	1	64.00
65.00	06500	19	38,756	0	0	4	65.00
66.00	06600	16	33,047	0	0	2	66.00
66.01	06601	3	6,886	0	0	0	66.01
67.00	06700	2	3,398	0	0	0	67.00
68.00	06800	2	3,366	0	0	0	68.00
69.00	06900	10	21,667	0	0	5	69.00
69.01	06901	1	2,969	0	0	0	69.01
70.00	07000	2	3,714	0	0	0	70.00
71.00	07100	0	0	3,474,783	0	1	71.00
72.00	07200	0	0	0	0	1	72.00
73.00	07300	0	0	0	1,923,837	9	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03330	2	4,173	0	0	2	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	24	50,222	0	0	2	90.00
91.00	09100	31	64,742	0	0	9	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	0	0	0	0	0	99.10
99.20	09920	0	0	0	0	0	99.20
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		446	903,496	3,474,783	1,923,837	100	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	1	2,135	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	2	3,897	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00							201.00
202.00		1,412,222	1,810,728	426,978	2,168,798	1,423,031	202.00
203.00		3,145.260579	1.990844	0.122879	1.127329	14,230.310000	203.00
204.00		146,608	133,199	95,849	64,323	109,250	204.00
205.00		326.521158	0.146448	0.027584	0.033435	1,092.500000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0034

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

Worksheet B-1

Date/Time Prepared:  
5/28/2019 11:34 am

Cost Center Description		CAFETERIA (FULL TIME EQUIVALENT)	NURSING ADMINISTRATION (FULL TIME EQUIVALENT)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
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: 14-0034

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

Worksheet B-1  
Date/Time Prepared:  
5/28/2019 11:34 am

Cost Center Description		SOCIAL SERVICE	
		(TIME SPENT)	
		17.00	
<b>GENERAL SERVICE COST CENTERS</b>			
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 SERVICE & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
43.00	04300	NURSERY	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	55.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
66.01	06601	CLINICAL NUTRITION	66.01
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
69.01	06901	CARDIAC REHABILITATION	69.01
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	03330	ENDOSCOPY	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
99.10	09910	CORF	99.10
99.20	09920	OPT	99.20
<b>SPECIAL PURPOSE COST CENTERS</b>			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	NONREIMBURSABLE	194.00
194.01	07951	RETAIL PHARMACY	194.01
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	206.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet B-1 Date/Time Prepared: 5/28/2019 11:34 am
Cost Center Description		SOCIAL SERVICE		
		(TIME SPENT)		
		17.00		
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)			207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/28/2019 11:34 am
			Title XVIII	Hospital	PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
			Total Costs	RCE Disallowance	Total Costs
	1.00	2.00	3.00	4.00	5.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		15,355,171	0	15,355,171
31.00	03100 INTENSIVE CARE UNIT		3,770,220	0	3,770,220
40.00	04000 SUBPROVIDER - I/PF		4,581,173	0	4,581,173
43.00	04300 NURSERY		485,660	0	485,660
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM		6,077,813	0	6,077,813
51.00	05100 RECOVERY ROOM		566,534	0	566,534
52.00	05200 DELIVERY ROOM & LABOR ROOM		1,903,689	0	1,903,689
53.00	05300 ANESTHESIOLOGY		594,380	0	594,380
54.00	05400 RADIOLOGY-DIAGNOSTIC		2,576,631	0	2,576,631
55.00	05500 RADIOLOGY - THERAPEUTIC		1,943,739	252,834	2,196,573
56.00	05600 RADIOISOTOPE		732,779	0	732,779
57.00	05700 CT SCAN		909,932	0	909,932
58.00	05800 MRI		442,289	0	442,289
59.00	05900 CARDIAC CATHETERIZATION		556,502	0	556,502
60.00	06000 LABORATORY		6,249,697	0	6,249,697
64.00	06400 INTRAVENOUS THERAPY		488,846	0	488,846
65.00	06500 RESPIRATORY THERAPY	0	2,195,952	515	2,196,467
66.00	06600 PHYSICAL THERAPY	0	2,403,639	0	2,403,639
66.01	06601 CLINICAL NUTRITION	0	305,516	0	305,516
67.00	06700 OCCUPATIONAL THERAPY	0	249,267	0	249,267
68.00	06800 SPEECH PATHOLOGY	0	206,235	0	206,235
69.00	06900 ELECTROCARDIOLOGY		1,654,866	0	1,654,866
69.01	06901 CARDIAC REHABILITATION		132,725	0	132,725
70.00	07000 ELECTROENCEPHALOGRAPHY		200,486	515	201,001
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT		4,789,970	0	4,789,970
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS		1,066,128	0	1,066,128
73.00	07300 DRUGS CHARGED TO PATIENTS		6,765,609	0	6,765,609
74.00	07400 RENAL DIALYSIS		197,953	0	197,953
76.00	03330 ENDOSCOPY		312,679	13,150	325,829
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC		3,280,202	1,807	3,282,009
91.00	09100 EMERGENCY		4,274,325	0	4,274,325
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)		2,219,047	0	2,219,047
<b>OTHER REIMBURSABLE COST CENTERS</b>					
99.10	09910 CORF		0	0	0
99.20	09920 OPT		0	0	0
200.00	Subtotal (see instructions)	0	77,489,654	268,821	77,758,475
201.00	Less Observation Beds		2,219,047		2,219,047
202.00	Total (see instructions)	0	75,270,607	268,821	75,539,428

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0034		Period: From 01/01/2018 To 12/31/2018		Worksheet C Part I Date/Time Prepared: 5/28/2019 11:34 am		
			Title XVIII			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	19,409,842		19,409,842				30.00
31.00	03100	INTENSIVE CARE UNIT	3,512,797		3,512,797				31.00
40.00	04000	SUBPROVIDER - IPF	5,376,858		5,376,858				40.00
43.00	04300	NURSERY	557,820		557,820				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	9,830,053	19,758,572	29,588,625	0.205410	0.000000		50.00
51.00	05100	RECOVERY ROOM	1,703,814	2,282,618	3,986,432	0.142116	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,874,425	1,236,702	4,111,127	0.463058	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	2,452,037	2,407,941	4,859,978	0.122301	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,585,573	10,955,594	13,541,167	0.190281	0.000000		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	93,855	8,196,319	8,290,174	0.234463	0.000000		55.00
56.00	05600	RADIOISOTOPE	504,472	5,959,945	6,464,417	0.113356	0.000000		56.00
57.00	05700	CT SCAN	7,275,309	26,241,045	33,516,354	0.027149	0.000000		57.00
58.00	05800	MRI	628,420	5,913,914	6,542,334	0.067604	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	735,320	1,687,711	2,423,031	0.229672	0.000000		59.00
60.00	06000	LABORATORY	18,497,074	31,376,423	49,873,497	0.125311	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	12,420	1,890,611	1,903,031	0.256878	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	7,550,194	4,665,551	12,215,745	0.179764	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	1,414,478	5,434,354	6,848,832	0.350956	0.000000		66.00
66.01	06601	CLINICAL NUTRITION	85	59,286	59,371	5.145879	0.000000		66.01
67.00	06700	OCCUPATIONAL THERAPY	201,869	605,658	807,527	0.308679	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	126,772	232,229	359,001	0.574469	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	5,559,100	9,388,528	14,947,628	0.110711	0.000000		69.00
69.01	06901	CARDIAC REHABILITATION	285	351,135	351,420	0.377682	0.000000		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	157,954	681,698	839,652	0.238773	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	2,927,490	697,389	3,624,879	1.321415	0.000000		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	1,148,863	640,946	1,789,809	0.595666	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,139,514	13,277,004	26,416,518	0.256113	0.000000		73.00
74.00	07400	RENAL DIALYSIS	456,650	56,590	513,240	0.385693	0.000000		74.00
76.00	03330	ENDOSCOPY	132,685	2,289,447	2,422,132	0.129092	0.000000		76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	5,152	5,567,605	5,572,757	0.588614	0.000000		90.00
91.00	09100	EMERGENCY	6,557,361	19,669,677	26,227,038	0.162974	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	348,331	1,835,946	2,184,277	1.015918	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
99.10	09910	CORF	0	0	0				99.10
99.20	09920	OPT	0	0	0				99.20
200.00		Subtotal (see instructions)	115,776,872	183,360,438	299,137,310				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	115,776,872	183,360,438	299,137,310				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/28/2019 11:34 am
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.205410		50.00
51.00	05100 RECOVERY ROOM	0.142116		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.463058		52.00
53.00	05300 ANESTHESIOLOGY	0.122301		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.190281		54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.264961		55.00
56.00	05600 RADIOISOTOPE	0.113356		56.00
57.00	05700 CT SCAN	0.027149		57.00
58.00	05800 MRI	0.067604		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.229672		59.00
60.00	06000 LABORATORY	0.125311		60.00
64.00	06400 INTRAVENOUS THERAPY	0.256878		64.00
65.00	06500 RESPIRATORY THERAPY	0.179806		65.00
66.00	06600 PHYSICAL THERAPY	0.350956		66.00
66.01	06601 CLINICAL NUTRITION	5.145879		66.01
67.00	06700 OCCUPATIONAL THERAPY	0.308679		67.00
68.00	06800 SPEECH PATHOLOGY	0.574469		68.00
69.00	06900 ELECTROCARDIOLOGY	0.110711		69.00
69.01	06901 CARDIAC REHABILITATION	0.377682		69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.239386		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	1.321415		71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.595666		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.256113		73.00
74.00	07400 RENAL DIALYSIS	0.385693		74.00
76.00	03330 ENDOSCOPY	0.134522		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.588938		90.00
91.00	09100 EMERGENCY	0.162974		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	1.015918		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.10	09910 CORF			99.10
99.20	09920 OPT			99.20
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: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/28/2019 11:34 am	
			Title XIX	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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS		15,355,171	0	15,355,171	30.00
31.00	03100 INTENSIVE CARE UNIT		3,770,220	0	3,770,220	31.00
40.00	04000 SUBPROVIDER - I/PF		4,581,173	0	4,581,173	40.00
43.00	04300 NURSERY		485,660	0	485,660	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM		6,077,813	0	6,077,813	50.00
51.00	05100 RECOVERY ROOM		566,534	0	566,534	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		1,903,689	0	1,903,689	52.00
53.00	05300 ANESTHESIOLOGY		594,380	0	594,380	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		2,576,631	0	2,576,631	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC		1,943,739	252,834	2,196,573	55.00
56.00	05600 RADIOISOTOPE		732,779	0	732,779	56.00
57.00	05700 CT SCAN		909,932	0	909,932	57.00
58.00	05800 MRI		442,289	0	442,289	58.00
59.00	05900 CARDIAC CATHETERIZATION		556,502	0	556,502	59.00
60.00	06000 LABORATORY		6,249,697	0	6,249,697	60.00
64.00	06400 INTRAVENOUS THERAPY		488,846	0	488,846	64.00
65.00	06500 RESPIRATORY THERAPY	0	2,195,952	515	2,196,467	65.00
66.00	06600 PHYSICAL THERAPY	0	2,403,639	0	2,403,639	66.00
66.01	06601 CLINICAL NUTRITION	0	305,516	0	305,516	66.01
67.00	06700 OCCUPATIONAL THERAPY	0	249,267	0	249,267	67.00
68.00	06800 SPEECH PATHOLOGY	0	206,235	0	206,235	68.00
69.00	06900 ELECTROCARDIOLOGY		1,654,866	0	1,654,866	69.00
69.01	06901 CARDIAC REHABILITATION		132,725	0	132,725	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY		200,486	515	201,001	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT		4,789,970	0	4,789,970	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS		1,066,128	0	1,066,128	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		6,765,609	0	6,765,609	73.00
74.00	07400 RENAL DIALYSIS		197,953	0	197,953	74.00
76.00	03330 ENDOSCOPY		312,679	13,150	325,829	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC		3,280,202	1,807	3,282,009	90.00
91.00	09100 EMERGENCY		4,274,325	0	4,274,325	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)		2,219,047	0	2,219,047	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10	09910 CORF		0	0	0	99.10
99.20	09920 OPT		0	0	0	99.20
200.00	Subtotal (see instructions)	0	77,489,654	268,821	77,758,475	200.00
201.00	Less Observation Beds		2,219,047		2,219,047	201.00
202.00	Total (see instructions)	0	75,270,607	268,821	75,539,428	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0034

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/28/2019 11:34 am

		Title XIX			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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	19,409,842		19,409,842		30.00
31.00	03100	INTENSIVE CARE UNIT	3,512,797		3,512,797		31.00
40.00	04000	SUBPROVIDER - IPF	5,376,858		5,376,858		40.00
43.00	04300	NURSERY	557,820		557,820		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	9,830,053	19,758,572	29,588,625	0.205410	50.00
51.00	05100	RECOVERY ROOM	1,703,814	2,282,618	3,986,432	0.142116	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,874,425	1,236,702	4,111,127	0.463058	52.00
53.00	05300	ANESTHESIOLOGY	2,452,037	2,407,941	4,859,978	0.122301	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,585,573	10,955,594	13,541,167	0.190281	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	93,855	8,196,319	8,290,174	0.234463	55.00
56.00	05600	RADIOISOTOPE	504,472	5,959,945	6,464,417	0.113356	56.00
57.00	05700	CT SCAN	7,275,309	26,241,045	33,516,354	0.027149	57.00
58.00	05800	MRI	628,420	5,913,914	6,542,334	0.067604	58.00
59.00	05900	CARDIAC CATHETERIZATION	735,320	1,687,711	2,423,031	0.229672	59.00
60.00	06000	LABORATORY	18,497,074	31,376,423	49,873,497	0.125311	60.00
64.00	06400	INTRAVENOUS THERAPY	12,420	1,890,611	1,903,031	0.256878	64.00
65.00	06500	RESPIRATORY THERAPY	7,550,194	4,665,551	12,215,745	0.179764	65.00
66.00	06600	PHYSICAL THERAPY	1,414,478	5,434,354	6,848,832	0.350956	66.00
66.01	06601	CLINICAL NUTRITION	85	59,286	59,371	5.145879	66.01
67.00	06700	OCCUPATIONAL THERAPY	201,869	605,658	807,527	0.308679	67.00
68.00	06800	SPEECH PATHOLOGY	126,772	232,229	359,001	0.574469	68.00
69.00	06900	ELECTROCARDIOLOGY	5,559,100	9,388,528	14,947,628	0.110711	69.00
69.01	06901	CARDIAC REHABILITATION	285	351,135	351,420	0.377682	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	157,954	681,698	839,652	0.238773	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	2,927,490	697,389	3,624,879	1.321415	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	1,148,863	640,946	1,789,809	0.595666	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,139,514	13,277,004	26,416,518	0.256113	73.00
74.00	07400	RENAL DIALYSIS	456,650	56,590	513,240	0.385693	74.00
76.00	03330	ENDOSCOPY	132,685	2,289,447	2,422,132	0.129092	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	5,152	5,567,605	5,572,757	0.588614	90.00
91.00	09100	EMERGENCY	6,557,361	19,669,677	26,227,038	0.162974	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	348,331	1,835,946	2,184,277	1.015918	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0		99.10
99.20	09920	OPT	0	0	0		99.20
200.00		Subtotal (see instructions)	115,776,872	183,360,438	299,137,310		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	115,776,872	183,360,438	299,137,310		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/28/2019 11:34 am
		Title XIX	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.205410		50.00
51.00	05100 RECOVERY ROOM	0.142116		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.463058		52.00
53.00	05300 ANESTHESIOLOGY	0.122301		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.190281		54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.264961		55.00
56.00	05600 RADIOISOTOPE	0.113356		56.00
57.00	05700 CT SCAN	0.027149		57.00
58.00	05800 MRI	0.067604		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.229672		59.00
60.00	06000 LABORATORY	0.125311		60.00
64.00	06400 INTRAVENOUS THERAPY	0.256878		64.00
65.00	06500 RESPIRATORY THERAPY	0.179806		65.00
66.00	06600 PHYSICAL THERAPY	0.350956		66.00
66.01	06601 CLINICAL NUTRITION	5.145879		66.01
67.00	06700 OCCUPATIONAL THERAPY	0.308679		67.00
68.00	06800 SPEECH PATHOLOGY	0.574469		68.00
69.00	06900 ELECTROCARDIOLOGY	0.110711		69.00
69.01	06901 CARDIAC REHABILITATION	0.377682		69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.239386		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	1.321415		71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.595666		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.256113		73.00
74.00	07400 RENAL DIALYSIS	0.385693		74.00
76.00	03330 ENDOSCOPY	0.134522		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.588938		90.00
91.00	09100 EMERGENCY	0.162974		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	1.015918		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.10	09910 CORF			99.10
99.20	09920 OPT			99.20
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-0034

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

Worksheet C Part II Date/Time Prepared: 5/28/2019 11:34 am

			Title XIX			Hospital		PPS	
Cost Center Description			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
			1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	6,077,813	983,546	5,094,267	0	0	50.00	
51.00	05100	RECOVERY ROOM	566,534	17,972	548,562	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,903,689	167,905	1,735,784	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	594,380	40,911	553,469	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,576,631	371,783	2,204,848	0	0	54.00	
55.00	05500	RADIOLOGY - THERAPEUTIC	1,943,739	222,785	1,720,954	0	0	55.00	
56.00	05600	RADIOISOTOPE	732,779	42,969	689,810	0	0	56.00	
57.00	05700	CT SCAN	909,932	97,865	812,067	0	0	57.00	
58.00	05800	MRI	442,289	133,548	308,741	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	556,502	85,828	470,674	0	0	59.00	
60.00	06000	LABORATORY	6,249,697	239,529	6,010,168	0	0	60.00	
64.00	06400	INTRAVENOUS THERAPY	488,846	31,096	457,750	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	2,195,952	112,523	2,083,429	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	2,403,639	228,803	2,174,836	0	0	66.00	
66.01	06601	CLINICAL NUTRITION	305,516	9,224	296,292	0	0	66.01	
67.00	06700	OCCUPATIONAL THERAPY	249,267	7,571	241,696	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	206,235	30,748	175,487	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	1,654,866	184,321	1,470,545	0	0	69.00	
69.01	06901	CARDIAC REHABILITATION	132,725	5,405	127,320	0	0	69.01	
70.00	07000	ELECTROENCEPHALOGRAPHY	200,486	10,504	189,982	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	4,789,970	205,513	4,584,457	0	0	71.00	
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	1,066,128	27,355	1,038,773	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	6,765,609	185,722	6,579,887	0	0	73.00	
74.00	07400	RENAL DIALYSIS	197,953	4,942	193,011	0	0	74.00	
76.00	03330	ENDOSCOPY	312,679	13,667	299,012	0	0	76.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>									
90.00	09000	CLINIC	3,280,202	172,148	3,108,054	0	0	90.00	
91.00	09100	EMERGENCY	4,274,325	266,120	4,008,205	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	2,219,047	201,223	2,017,824	0	0	92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>									
99.10	09910	CORF	0	0	0	0	0	99.10	
99.20	09920	OPT	0	0	0	0	0	99.20	
200.00		Subtotal (sum of lines 50 thru 199)	53,297,430	4,101,526	49,195,904	0	0	200.00	
201.00		Less Observation Beds	2,219,047	201,223	2,017,824	0	0	201.00	
202.00		Total (line 200 minus line 201)	51,078,383	3,900,303	47,178,080	0	0	202.00	

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-0034

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

Worksheet C Part II Date/Time Prepared: 5/28/2019 11:34 am

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	PPS
		6.00	7.00	8.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	6,077,813	29,588,625	0.205410		50.00
51.00	05100 RECOVERY ROOM	566,534	3,986,432	0.142116		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,903,689	4,111,127	0.463058		52.00
53.00	05300 ANESTHESIOLOGY	594,380	4,859,978	0.122301		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,576,631	13,541,167	0.190281		54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	1,943,739	8,290,174	0.234463		55.00
56.00	05600 RADIOISOTOPE	732,779	6,464,417	0.113356		56.00
57.00	05700 CT SCAN	909,932	33,516,354	0.027149		57.00
58.00	05800 MRI	442,289	6,542,334	0.067604		58.00
59.00	05900 CARDIAC CATHETERIZATION	556,502	2,423,031	0.229672		59.00
60.00	06000 LABORATORY	6,249,697	49,873,497	0.125311		60.00
64.00	06400 INTRAVENOUS THERAPY	488,846	1,903,031	0.256878		64.00
65.00	06500 RESPIRATORY THERAPY	2,195,952	12,215,745	0.179764		65.00
66.00	06600 PHYSICAL THERAPY	2,403,639	6,848,832	0.350956		66.00
66.01	06601 CLINICAL NUTRITION	305,516	59,371	5.145879		66.01
67.00	06700 OCCUPATIONAL THERAPY	249,267	807,527	0.308679		67.00
68.00	06800 SPEECH PATHOLOGY	206,235	359,001	0.574469		68.00
69.00	06900 ELECTROCARDIOLOGY	1,654,866	14,947,628	0.110711		69.00
69.01	06901 CARDIAC REHABILITATION	132,725	351,420	0.377682		69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	200,486	839,652	0.238773		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	4,789,970	3,624,879	1.321415		71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	1,066,128	1,789,809	0.595666		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	6,765,609	26,416,518	0.256113		73.00
74.00	07400 RENAL DIALYSIS	197,953	513,240	0.385693		74.00
76.00	03330 ENDOSCOPY	312,679	2,422,132	0.129092		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	3,280,202	5,572,757	0.588614		90.00
91.00	09100 EMERGENCY	4,274,325	26,227,038	0.162974		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	2,219,047	2,184,277	1.015918		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10	09910 CORF	0	0	0.000000		99.10
99.20	09920 OPT	0	0	0.000000		99.20
200.00	Subtotal (sum of lines 50 thru 199)	53,297,430	270,279,993			200.00
201.00	Less Observation Beds	2,219,047	0			201.00
202.00	Total (line 200 minus line 201)	51,078,383	270,279,993			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part I Date/Time Prepared: 5/28/2019 11:34 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
Title XVIII Hospital PPS								
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	1,392,401	0	1,392,401	14,310	97.30	30.00	
31.00	INTENSIVE CARE UNIT	264,996	0	264,996	1,501	176.55	31.00	
40.00	SUBPROVIDER - IPF	276,367		276,367	5,050	54.73	40.00	
43.00	NURSERY	71,357		71,357	514	138.83	43.00	
200.00	Total (lines 30 through 199)	2,005,121		2,005,121	21,375		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	8,211	798,930					30.00
31.00	INTENSIVE CARE UNIT	942	166,310					31.00
40.00	SUBPROVIDER - IPF	1,393	76,239					40.00
43.00	NURSERY	0	0					43.00
200.00	Total (lines 30 through 199)	10,546	1,041,479					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Prepared: 5/28/2019 11:34 am
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Cost Center Description		Title XVIII			Hospital	PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	983,546	29,588,625	0.033241	5,675,617	188,663	50.00
51.00	05100 RECOVERY ROOM	17,972	3,986,432	0.004508	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	167,905	4,111,127	0.040842	0	0	52.00
53.00	05300 ANESTHESIOLOGY	40,911	4,859,978	0.008418	837,522	7,050	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	371,783	13,541,167	0.027456	1,734,360	47,619	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	222,785	8,290,174	0.026873	0	0	55.00
56.00	05600 RADIOISOTOPE	42,969	6,464,417	0.006647	309,732	2,059	56.00
57.00	05700 CT SCAN	97,865	33,516,354	0.002920	4,346,550	12,692	57.00
58.00	05800 MRI	133,548	6,542,334	0.020413	358,090	7,310	58.00
59.00	05900 CARDIAC CATHETERIZATION	85,828	2,423,031	0.035422	133,695	4,736	59.00
60.00	06000 LABORATORY	239,529	49,873,497	0.004803	11,060,202	53,122	60.00
64.00	06400 INTRAVENOUS THERAPY	31,096	1,903,031	0.016340	250	4	64.00
65.00	06500 RESPIRATORY THERAPY	112,523	12,215,745	0.009211	4,916,810	45,289	65.00
66.00	06600 PHYSICAL THERAPY	228,803	6,848,832	0.033408	1,190,447	39,770	66.00
66.01	06601 CLINICAL NUTRITION	9,224	59,371	0.155362	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	7,571	807,527	0.009376	1,210	11	67.00
68.00	06800 SPEECH PATHOLOGY	30,748	359,001	0.085649	97,843	8,380	68.00
69.00	06900 ELECTROCARDIOLOGY	184,321	14,947,628	0.012331	3,911,693	48,235	69.00
69.01	06901 CARDIAC REHABILITATION	5,405	351,420	0.015380	285	4	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	10,504	839,652	0.012510	96,156	1,203	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	205,513	3,624,879	0.056695	2,053,418	116,419	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	27,355	1,789,809	0.015284	582,301	8,900	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	185,722	26,416,518	0.007031	8,301,589	58,368	73.00
74.00	07400 RENAL DIALYSIS	4,942	513,240	0.009629	285,950	2,753	74.00
76.00	03330 ENDOSCOPY	13,667	2,422,132	0.005643	5,650	32	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	172,148	5,572,757	0.030891	210	6	90.00
91.00	09100 EMERGENCY	266,120	26,227,038	0.010147	3,421,864	34,722	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	201,223	2,184,277	0.092123	240,061	22,115	92.00
200.00	Total (lines 50 through 199)	4,101,526	270,279,993		49,561,505	709,462	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part III Date/Time Prepared: 5/28/2019 11:34 am
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Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	14,310	0.00	8,211	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,501	0.00	942	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	5,050	0.00	1,393	40.00
43.00	04300	NURSERY		0	514	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	21,375		10,546	200.00
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
			9.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0					30.00
31.00	03100	INTENSIVE CARE UNIT	0					31.00
40.00	04000	SUBPROVIDER - IPF	0					40.00
43.00	04300	NURSERY	0					43.00
200.00		Total (lines 30 through 199)	0					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/28/2019 11:34 am
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Cost Center Description	Title XVIII				Hospital		PPS
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
	1.00	2A	2.00	3A	3.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00	
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00	
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
55.00 05500 RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00	
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00	
57.00 05700 CT SCAN	0	0	0	0	0	57.00	
58.00 05800 MRI	0	0	0	0	0	58.00	
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
60.00 06000 LABORATORY	0	0	0	0	0	60.00	
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00	
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00	
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00	
66.01 06601 CLINICAL NUTRITION	0	0	0	0	0	66.01	
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
69.01 06901 CARDIAC REHABILITATION	0	0	0	0	0	69.01	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00	
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00	
76.00 03330 ENDOSCOPY	0	0	0	0	0	76.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000 CLINIC	0	0	0	0	0	90.00	
91.00 09100 EMERGENCY	0	0	0	0	0	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	0	92.00	
200.00 Total (lines 50 through 199)	0	0	0	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/28/2019 11:34 am
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Cost Center Description		Title XVIII			Hospital	PPS		
		All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	29,588,625	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	3,986,432	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	4,111,127	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	4,859,978	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,541,167	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	8,290,174	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	6,464,417	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	33,516,354	0.000000	57.00
58.00	05800	MRI	0	0	0	6,542,334	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	2,423,031	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	49,873,497	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,903,031	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	12,215,745	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,848,832	0.000000	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	59,371	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	807,527	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	359,001	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,947,628	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	351,420	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	839,652	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	3,624,879	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	1,789,809	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	26,416,518	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	513,240	0.000000	74.00
76.00	03330	ENDOSCOPY	0	0	0	2,422,132	0.000000	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	5,572,757	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	26,227,038	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	2,184,277	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	270,279,993		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/28/2019 11:34 am
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Cost Center Description		Title XVIII				Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000 OPERATING ROOM	0.000000	5,675,617	0	8,641,891	0	50.00	
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00	
53.00	05300 ANESTHESIOLOGY	0.000000	837,522	0	941,740	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	1,734,360	0	7,695,855	0	54.00	
55.00	05500 RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00	
56.00	05600 RADIOISOTOPE	0.000000	309,732	0	3,054,075	0	56.00	
57.00	05700 CT SCAN	0.000000	4,346,550	0	8,944,450	0	57.00	
58.00	05800 MRI	0.000000	358,090	0	2,154,300	0	58.00	
59.00	05900 CARDIAC CATHETERIZATION	0.000000	133,695	0	339,970	0	59.00	
60.00	06000 LABORATORY	0.000000	11,060,202	0	6,279,303	0	60.00	
64.00	06400 INTRAVENOUS THERAPY	0.000000	250	0	234,160	0	64.00	
65.00	06500 RESPIRATORY THERAPY	0.000000	4,916,810	0	2,238,517	0	65.00	
66.00	06600 PHYSICAL THERAPY	0.000000	1,190,447	0	84,750	0	66.00	
66.01	06601 CLINICAL NUTRITION	0.000000	0	0	0	0	66.01	
67.00	06700 OCCUPATIONAL THERAPY	0.000000	1,210	0	63,070	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0.000000	97,843	0	8,521	0	68.00	
69.00	06900 ELECTROCARDIOLOGY	0.000000	3,911,693	0	4,402,581	0	69.00	
69.01	06901 CARDIAC REHABILITATION	0.000000	285	0	230,565	0	69.01	
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	96,156	0	154,194	0	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.000000	2,053,418	0	342,139	0	71.00	
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	582,301	0	421,057	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	8,301,589	0	9,442,669	0	73.00	
74.00	07400 RENAL DIALYSIS	0.000000	285,950	0	6,050	0	74.00	
76.00	03330 ENDOSCOPY	0.000000	5,650	0	47,880	0	76.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000 CLINIC	0.000000	210	0	138,589	0	90.00	
91.00	09100 EMERGENCY	0.000000	3,421,864	0	6,396,273	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0.000000	240,061	0	992,611	0	92.00	
200.00	Total (lines 50 through 199)		49,561,505	0	63,255,210	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/28/2019 11:34 am
Title XVIII			Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	0.205410	8,641,891	0	0	1,775,131	50.00	
51.00 05100 RECOVERY ROOM	0.142116	0	0	0	0	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.463058	0	0	0	0	52.00	
53.00 05300 ANESTHESIOLOGY	0.122301	941,740	0	0	115,176	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.190281	7,695,855	0	0	1,464,375	54.00	
55.00 05500 RADIOLOGY - THERAPEUTIC	0.234463	0	0	0	0	55.00	
56.00 05600 RADIOISOTOPE	0.113356	3,054,075	0	0	346,198	56.00	
57.00 05700 CT SCAN	0.027149	8,944,450	0	0	242,833	57.00	
58.00 05800 MRI	0.067604	2,154,300	0	0	145,639	58.00	
59.00 05900 CARDIAC CATHETERIZATION	0.229672	339,970	0	0	78,082	59.00	
60.00 06000 LABORATORY	0.125311	6,279,303	0	0	786,866	60.00	
64.00 06400 INTRAVENOUS THERAPY	0.256878	234,160	0	0	60,151	64.00	
65.00 06500 RESPIRATORY THERAPY	0.179764	2,238,517	0	0	402,405	65.00	
66.00 06600 PHYSICAL THERAPY	0.350956	84,750	0	0	29,744	66.00	
66.01 06601 CLINICAL NUTRITION	5.145879	0	0	0	0	66.01	
67.00 06700 OCCUPATIONAL THERAPY	0.308679	63,070	0	0	19,468	67.00	
68.00 06800 SPEECH PATHOLOGY	0.574469	8,521	0	0	4,895	68.00	
69.00 06900 ELECTROCARDIOLOGY	0.110711	4,402,581	0	0	487,414	69.00	
69.01 06901 CARDIAC REHABILITATION	0.377682	230,565	0	0	87,080	69.01	
70.00 07000 ELECTROENCEPHALOGRAPHY	0.238773	154,194	0	0	36,817	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	1.321415	342,139	0	0	452,108	71.00	
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.595666	421,057	0	0	250,809	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0.256113	9,442,669	0	184,859	2,418,390	73.00	
74.00 07400 RENAL DIALYSIS	0.385693	6,050	0	0	2,333	74.00	
76.00 03330 ENDOSCOPY	0.129092	47,880	0	0	6,181	76.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000 CLINIC	0.588614	138,589	0	0	81,575	90.00	
91.00 09100 EMERGENCY	0.162974	6,396,273	0	0	1,042,426	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT)	1.015918	992,611	0	0	1,008,411	92.00	
200.00		Subtotal (see instructions)	63,255,210	0	184,859	11,344,507	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0	0		201.00
202.00		Net Charges (line 200 - line 201)	63,255,210	0	184,859	11,344,507	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/28/2019 11:34 am
Title XVIII		Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00 05500 RADIOLOGY - THERAPEUTIC	0	0		55.00
56.00 05600 RADIOISOTOPE	0	0		56.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MRI	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
66.01 06601 CLINICAL NUTRITION	0	0		66.01
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
69.01 06901 CARDIAC REHABILITATION	0	0		69.01
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	0	47,345		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.00 03330 ENDOSCOPY	0	0		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT)	0	0		92.00
200.00 Subtotal (see instructions)	0	47,345		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	0	47,345		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 14-0034 Component CCN: 14-S034	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Prepared: 5/28/2019 11:34 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	983,546	29,588,625	0.033241	0	0	50.00
51.00	05100 RECOVERY ROOM	17,972	3,986,432	0.004508	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	167,905	4,111,127	0.040842	0	0	52.00
53.00	05300 ANESTHESIOLOGY	40,911	4,859,978	0.008418	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	371,783	13,541,167	0.027456	13,910	382	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	222,785	8,290,174	0.026873	0	0	55.00
56.00	05600 RADIOISOTOPE	42,969	6,464,417	0.006647	3,525	23	56.00
57.00	05700 CT SCAN	97,865	33,516,354	0.002920	62,550	183	57.00
58.00	05800 MRI	133,548	6,542,334	0.020413	10,000	204	58.00
59.00	05900 CARDIAC CATHETERIZATION	85,828	2,423,031	0.035422	0	0	59.00
60.00	06000 LABORATORY	239,529	49,873,497	0.004803	403,826	1,940	60.00
64.00	06400 INTRAVENOUS THERAPY	31,096	1,903,031	0.016340	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	112,523	12,215,745	0.009211	101,685	937	65.00
66.00	06600 PHYSICAL THERAPY	228,803	6,848,832	0.033408	11,135	372	66.00
66.01	06601 CLINICAL NUTRITION	9,224	59,371	0.155362	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	7,571	807,527	0.009376	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	30,748	359,001	0.085649	800	69	68.00
69.00	06900 ELECTROCARDIOLOGY	184,321	14,947,628	0.012331	27,476	339	69.00
69.01	06901 CARDIAC REHABILITATION	5,405	351,420	0.015380	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	10,504	839,652	0.012510	12,908	161	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	205,513	3,624,879	0.056695	7,000	397	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	27,355	1,789,809	0.015284	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	185,722	26,416,518	0.007031	117,070	823	73.00
74.00	07400 RENAL DIALYSIS	4,942	513,240	0.009629	5,320	51	74.00
76.00	03330 ENDOSCOPY	13,667	2,422,132	0.005643	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	172,148	5,572,757	0.030891	0	0	90.00
91.00	09100 EMERGENCY	266,120	26,227,038	0.010147	184,880	1,876	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	0	2,184,277	0.000000	0	0	92.00
200.00	Total (lines 50 through 199)	3,900,303	270,279,993		962,085	7,757	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0034 Component CCN: 14-S034	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/28/2019 11:34 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601 CLINICAL NUTRITION	0	0	0	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901 CARDIAC REHABILITATION	0	0	0	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03330 ENDOSCOPY	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	0	92.00
200.00	Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0034 Component CCN: 14-S034	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/28/2019 11:34 am
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Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7)		
		4.00	5.00	6.00	7.00	8.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	29,588,625	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	3,986,432	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	4,111,127	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	4,859,978	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,541,167	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	8,290,174	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	6,464,417	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	33,516,354	0.000000	57.00
58.00	05800	MRI	0	0	0	6,542,334	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	2,423,031	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	49,873,497	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,903,031	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	12,215,745	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,848,832	0.000000	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	59,371	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	807,527	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	359,001	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,947,628	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	351,420	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	839,652	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	3,624,879	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	1,789,809	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	26,416,518	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	513,240	0.000000	74.00
76.00	03330	ENDOSCOPY	0	0	0	2,422,132	0.000000	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	5,572,757	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	26,227,038	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	2,184,277	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	270,279,993		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0034 Component CCN: 14-S034	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/28/2019 11:34 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	13,910	0	84	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	3,525	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	62,550	0	0	0	57.00
58.00	05800	MRI	0.000000	10,000	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	403,826	0	1,342	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	101,685	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	11,135	0	0	0	66.00
66.01	06601	CLINICAL NUTRITION	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	800	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	27,476	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	12,908	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	7,000	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	117,070	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	5,320	0	0	0	74.00
76.00	03330	ENDOSCOPY	0.000000	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0.000000	0	0	331,025	0	90.00
91.00	09100	EMERGENCY	0.000000	184,880	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		962,085	0	332,451	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0034 Component CCN: 14-S034	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/28/2019 11:34 am
		Title XVIII	Subprovider - IPF	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		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0.205410	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.142116	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.463058	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.122301	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.190281	84	0	16	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.234463	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.113356	0	0	0	56.00
57.00	05700	CT SCAN	0.027149	0	0	0	57.00
58.00	05800	MRI	0.067604	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.229672	0	0	0	59.00
60.00	06000	LABORATORY	0.125311	1,342	0	168	60.00
64.00	06400	INTRAVENOUS THERAPY	0.256878	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.179764	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.350956	0	0	0	66.00
66.01	06601	CLINICAL NUTRITION	5.145879	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.308679	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.574469	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.110711	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.377682	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.238773	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1.321415	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.595666	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.256113	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.385693	0	0	0	74.00
76.00	03330	ENDOSCOPY	0.129092	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0.588614	331,025	0	194,846	90.00
91.00	09100	EMERGENCY	0.162974	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	1.015918	0	0	0	92.00
200.00		Subtotal (see instructions)		332,451	0	195,030	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net Charges (line 200 - line 201)		332,451	0	195,030	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0034 Component CCN: 14-S034	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/28/2019 11:34 am
Title XVIII		Subprovider - IPF	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	
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00 05000 OPERATING ROOM	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00 05500 RADIOLOGY - THERAPEUTIC	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	56.00
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MRI	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
66.01 06601 CLINICAL NUTRITION	0	0	66.01
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
69.01 06901 CARDIAC REHABILITATION	0	0	69.01
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	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
76.00 03330 ENDOSCOPY	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00 09000 CLINIC	0	0	90.00
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT)	0	0	92.00
200.00 Subtotal (see instructions)	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00 Net Charges (line 200 - line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part I Date/Time Prepared: 5/28/2019 11:34 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	1,392,401	0	1,392,401	14,310	97.30	30.00
31.00	INTENSIVE CARE UNIT	264,996	0	264,996	1,501	176.55	31.00
40.00	SUBPROVIDER - IPF	276,367	0	276,367	5,050	54.73	40.00
43.00	NURSERY	71,357		71,357	514	138.83	43.00
200.00	Total (lines 30 through 199)	2,005,121		2,005,121	21,375		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	625	60,813				
31.00	INTENSIVE CARE UNIT	134	23,658				
40.00	SUBPROVIDER - IPF	1,604	87,787				
43.00	NURSERY	265	36,790				
200.00	Total (lines 30 through 199)	2,628	209,048				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Prepared: 5/28/2019 11:34 am
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Cost Center Description		Title XIX			Hospital	PPS
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
		1.00	2.00	3.00	4.00	5.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	983,546	29,588,625	0.033241	0	0 50.00
51.00	05100 RECOVERY ROOM	17,972	3,986,432	0.004508	0	0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	167,905	4,111,127	0.040842	0	0 52.00
53.00	05300 ANESTHESIOLOGY	40,911	4,859,978	0.008418	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	371,783	13,541,167	0.027456	0	0 54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	222,785	8,290,174	0.026873	0	0 55.00
56.00	05600 RADIOISOTOPE	42,969	6,464,417	0.006647	0	0 56.00
57.00	05700 CT SCAN	97,865	33,516,354	0.002920	0	0 57.00
58.00	05800 MRI	133,548	6,542,334	0.020413	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	85,828	2,423,031	0.035422	0	0 59.00
60.00	06000 LABORATORY	239,529	49,873,497	0.004803	0	0 60.00
64.00	06400 INTRAVENOUS THERAPY	31,096	1,903,031	0.016340	0	0 64.00
65.00	06500 RESPIRATORY THERAPY	112,523	12,215,745	0.009211	0	0 65.00
66.00	06600 PHYSICAL THERAPY	228,803	6,848,832	0.033408	0	0 66.00
66.01	06601 CLINICAL NUTRITION	9,224	59,371	0.155362	0	0 66.01
67.00	06700 OCCUPATIONAL THERAPY	7,571	807,527	0.009376	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	30,748	359,001	0.085649	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	184,321	14,947,628	0.012331	0	0 69.00
69.01	06901 CARDIAC REHABILITATION	5,405	351,420	0.015380	0	0 69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	10,504	839,652	0.012510	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	205,513	3,624,879	0.056695	0	0 71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	27,355	1,789,809	0.015284	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	185,722	26,416,518	0.007031	0	0 73.00
74.00	07400 RENAL DIALYSIS	4,942	513,240	0.009629	0	0 74.00
76.00	03330 ENDOSCOPY	13,667	2,422,132	0.005643	0	0 76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	172,148	5,572,757	0.030891	0	0 90.00
91.00	09100 EMERGENCY	266,120	26,227,038	0.010147	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	201,223	2,184,277	0.092123	0	0 92.00
200.00	Total (lines 50 through 199)	4,101,526	270,279,993		0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part III Date/Time Prepared: 5/28/2019 11:34 am
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Cost Center Description		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
		1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00	
43.00	04300	NURSERY	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	200.00	
Cost Center Description		Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
		4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	14,310	0.00	625 30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	1,501	0.00	134 31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	5,050	0.00	1,604 40.00	
43.00	04300	NURSERY	0	0	514	0.00	265 43.00	
200.00		Total (lines 30 through 199)	0	0	21,375		2,628 200.00	
Cost Center Description		Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
		9.00						
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0					30.00
31.00	03100	INTENSIVE CARE UNIT	0					31.00
40.00	04000	SUBPROVIDER - IPF	0					40.00
43.00	04300	NURSERY	0					43.00
200.00		Total (lines 30 through 199)	0					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/28/2019 11:34 am
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Cost Center Description	Title XIX			Hospital		PPS	
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
	1.00	2A	2.00	3A	3.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	71.00
72.00	07200	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	0	0	0	74.00
76.00	03330	ENDOSCOPY	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/28/2019 11:34 am
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Cost Center Description		Title XIX			Hospital	PPS		
		All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
		4.00	5.00	6.00	7.00	8.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	29,588,625	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	3,986,432	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	4,111,127	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	4,859,978	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,541,167	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	8,290,174	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	6,464,417	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	33,516,354	0.000000	57.00
58.00	05800	MRI	0	0	0	6,542,334	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	2,423,031	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	49,873,497	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,903,031	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	12,215,745	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,848,832	0.000000	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	59,371	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	807,527	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	359,001	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,947,628	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	351,420	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	839,652	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	3,624,879	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	1,789,809	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	26,416,518	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	513,240	0.000000	74.00
76.00	03330	ENDOSCOPY	0	0	0	2,422,132	0.000000	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	5,572,757	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	26,227,038	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	2,184,277	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	270,279,993		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/28/2019 11:34 am
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Cost Center Description	Title XIX			Hospital		PPS
	Outpatient Ratio of Cost to Charges (col. 6 + col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
55.00 05500 RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00 05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00 05800 MRI	0.000000	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00 06000 LABORATORY	0.000000	0	0	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
66.01 06601 CLINICAL NUTRITION	0.000000	0	0	0	0	66.01
67.00 06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01 06901 CARDIAC REHABILITATION	0.000000	0	0	0	0	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0.000000	0	0	0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00 03330 ENDOSCOPY	0.000000	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0.000000	0	0	0	0	90.00
91.00 09100 EMERGENCY	0.000000	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT)	0.000000	0	0	0	0	92.00
200.00 Total (lines 50 through 199)		0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0034 Component CCN: 14-S034	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Prepared: 5/28/2019 11:34 am
Title XIX			Subprovider - IPF	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	983,546	29,588,625	0.033241	0	0	50.00
51.00	05100 RECOVERY ROOM	17,972	3,986,432	0.004508	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	167,905	4,111,127	0.040842	0	0	52.00
53.00	05300 ANESTHESIOLOGY	40,911	4,859,978	0.008418	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	371,783	13,541,167	0.027456	0	0	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	222,785	8,290,174	0.026873	0	0	55.00
56.00	05600 RADIOISOTOPE	42,969	6,464,417	0.006647	0	0	56.00
57.00	05700 CT SCAN	97,865	33,516,354	0.002920	0	0	57.00
58.00	05800 MRI	133,548	6,542,334	0.020413	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	85,828	2,423,031	0.035422	0	0	59.00
60.00	06000 LABORATORY	239,529	49,873,497	0.004803	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	31,096	1,903,031	0.016340	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	112,523	12,215,745	0.009211	0	0	65.00
66.00	06600 PHYSICAL THERAPY	228,803	6,848,832	0.033408	0	0	66.00
66.01	06601 CLINICAL NUTRITION	9,224	59,371	0.155362	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	7,571	807,527	0.009376	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	30,748	359,001	0.085649	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	184,321	14,947,628	0.012331	0	0	69.00
69.01	06901 CARDIAC REHABILITATION	5,405	351,420	0.015380	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	10,504	839,652	0.012510	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	205,513	3,624,879	0.056695	0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	27,355	1,789,809	0.015284	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	185,722	26,416,518	0.007031	0	0	73.00
74.00	07400 RENAL DIALYSIS	4,942	513,240	0.009629	0	0	74.00
76.00	03330 ENDOSCOPY	13,667	2,422,132	0.005643	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	172,148	5,572,757	0.030891	0	0	90.00
91.00	09100 EMERGENCY	266,120	26,227,038	0.010147	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	0	2,184,277	0.000000	0	0	92.00
200.00	Total (lines 50 through 199)	3,900,303	270,279,993		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0034 Component CCN: 14-S034	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/28/2019 11:34 am
Title XIX		Subprovider - IPF	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2.00	3A	3.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00 05500 RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MRI	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01 06601 CLINICAL NUTRITION	0	0	0	0	0	66.01
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01 06901 CARDIAC REHABILITATION	0	0	0	0	0	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00 03330 ENDOSCOPY	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	0	92.00
200.00 Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0034 Component CCN: 14-S034	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/28/2019 11:34 am
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Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7)		
		4.00	5.00	6.00	7.00	8.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	29,588,625	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	3,986,432	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	4,111,127	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	4,859,978	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,541,167	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	8,290,174	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	6,464,417	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	33,516,354	0.000000	57.00
58.00	05800	MRI	0	0	0	6,542,334	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	2,423,031	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	49,873,497	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,903,031	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	12,215,745	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,848,832	0.000000	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	59,371	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	807,527	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	359,001	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,947,628	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	351,420	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	839,652	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	3,624,879	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	1,789,809	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	26,416,518	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	513,240	0.000000	74.00
76.00	03330	ENDOSCOPY	0	0	0	2,422,132	0.000000	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	5,572,757	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	26,227,038	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	2,184,277	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	270,279,993		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0034 Component CCN: 14-S034	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/28/2019 11:34 am
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Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MRI	0.000000	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	0	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
66.01	06601 CLINICAL NUTRITION	0.000000	0	0	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901 CARDIAC REHABILITATION	0.000000	0	0	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.000000	0	0	0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03330 ENDOSCOPY	0.000000	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0.000000	0	0	0	0	92.00
200.00	Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/28/2019 11:34 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		14,310	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		14,310	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.		12,181	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		61	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		8,211	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
<b>SWING BED ADJUSTMENT</b>				
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)		15,355,171	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)		15,355,171	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		19,281,714	28.00
29.00	Private room charges (excluding swing-bed charges)		19,208,406	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		73,308	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.796359	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		1,576.92	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,201.77	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		375.15	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		298.75	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		3,639,074	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		11,716,097	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,073.04	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		8,810,731	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)		8,810,731	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0034		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1	
Date/Time Prepared: 5/28/2019 11:34 am		Title XVIII		Hospital		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
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	3,770,220	1,501	2,511.81	942	2,366,125		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)					11,106,122		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					22,282,978		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)					965,240		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					709,462		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,674,702		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					20,608,276		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					2,068		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,073.04		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					2,219,047		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0034		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/28/2019 11:34 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,392,401	15,355,171	0.090680	2,219,047	201,223	90.00
91.00	Nursing School cost	0	15,355,171	0.000000	2,219,047	0	91.00
92.00	Allied health cost	0	15,355,171	0.000000	2,219,047	0	92.00
93.00	All other Medical Education	0	15,355,171	0.000000	2,219,047	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0034 Component CCN: 14-S034	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/28/2019 11:34 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			5,050 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			5,050 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)			5,050 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)			1,393 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
<b>SWING BED ADJUSTMENT</b>				
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)			4,581,173 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)			4,581,173 27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)			4,581,173 37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			907.16 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,263,674 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			1,263,674 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0034 Component CCN: 14-S034		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/28/2019 11:34 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)		
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)				
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
					1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				156,225		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				1,419,899		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)				76,239		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				7,757		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				83,996		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)				1,335,903		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges				0		54.00
55.00	Target amount per discharge				0.00		55.00
56.00	Target amount (line 54 x line 55)				0		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0		57.00
58.00	Bonus payment (see instructions)				0		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0		61.00
62.00	Relief payment (see instructions)				0		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)				0		87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00		88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0034 Component CCN: 14-S034		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/28/2019 11:34 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	276,367	4,581,173	0.060327	0	0	90.00
91.00	Nursing School cost	0	4,581,173	0.000000	0	0	91.00
92.00	Allied health cost	0	4,581,173	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,581,173	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/28/2019 11:34 am
Cost Center Description		Title XIX	Hospital	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		14,310	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		14,310	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)		12,242	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)		625	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)		514	15.00
16.00	Nursery days (title V or XIX only)		265	16.00
<b>SWING BED ADJUSTMENT</b>				
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)		15,355,171	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)		15,355,171	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		15,355,171	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,073.04	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		670,650	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)		670,650	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0034		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/28/2019 11:34 am	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
Title XIX		1.00	2.00	3.00	4.00	5.00	
Hospital		485,660	514	944.86	265	250,388	42.00
PPS							
42.00	NURSERY (title V & XIX only)	485,660	514	944.86	265	250,388	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	3,770,220	1,501	2,511.81	134	336,583	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)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,257,621	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)					121,261	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					121,261	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,136,360	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					2,068	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,073.04	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,219,047	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0034		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/28/2019 11:34 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,392,401	15,355,171	0.090680	2,219,047	201,223	90.00
91.00	Nursing School cost	0	15,355,171	0.000000	2,219,047	0	91.00
92.00	Allied health cost	0	15,355,171	0.000000	2,219,047	0	92.00
93.00	All other Medical Education	0	15,355,171	0.000000	2,219,047	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0034 Component CCN: 14-S034	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/28/2019 11:34 am
		Title XIX	Subprovider - IPF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			5,050 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			5,050 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)			5,050 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)			1,604 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)			514 15.00
16.00	Nursery days (title V or XIX only)			265 16.00
<b>SWING BED ADJUSTMENT</b>				
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)			4,581,173 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)			4,581,173 27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)			4,581,173 37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			907.16 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,455,085 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			1,455,085 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0034		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1	
		Component CCN: 14-S034				Date/Time Prepared: 5/28/2019 11:34 am	
		Title XIX		Subprovider - IPF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
<b>Cost Center Description</b>							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	0	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,455,085	0	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					87,787	0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					87,787	0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,367,298	0	53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
54.00 Program discharges					0	0	54.00
55.00 Target amount per discharge					0.00	0	55.00
56.00 Target amount (line 54 x line 55)					0	0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	0	57.00
58.00 Bonus payment (see instructions)					0	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	0	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	0	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	0	61.00
62.00 Relief payment (see instructions)					0	0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	0	63.00
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	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	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	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	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	0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	0	69.00
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY</b>							
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
87.00 Total observation bed days (see instructions)					0	0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	0	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0034 Component CCN: 14-S034		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/28/2019 11:34 am	
		Title XIX		Subprovider - IPF		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	276,367	4,581,173	0.060327	0	0	90.00
91.00	Nursing School cost	0	4,581,173	0.000000	0	0	91.00
92.00	Allied health cost	0	4,581,173	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,581,173	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/28/2019 11:34 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		10,431,815	30.00
31.00	03100	INTENSIVE CARE UNIT		1,946,970	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.205410	5,675,617	50.00
51.00	05100	RECOVERY ROOM	0.142116	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.463058	0	52.00
53.00	05300	ANESTHESIOLOGY	0.122301	837,522	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.190281	1,734,360	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.264961	0	55.00
56.00	05600	RADIOISOTOPE	0.113356	309,732	56.00
57.00	05700	CT SCAN	0.027149	4,346,550	57.00
58.00	05800	MRI	0.067604	358,090	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.229672	133,695	59.00
60.00	06000	LABORATORY	0.125311	11,060,202	60.00
64.00	06400	INTRAVENOUS THERAPY	0.256878	250	64.00
65.00	06500	RESPIRATORY THERAPY	0.179806	4,916,810	65.00
66.00	06600	PHYSICAL THERAPY	0.350956	1,190,447	66.00
66.01	06601	CLINICAL NUTRITION	5.145879	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.308679	1,210	67.00
68.00	06800	SPEECH PATHOLOGY	0.574469	97,843	68.00
69.00	06900	ELECTROCARDIOLOGY	0.110711	3,911,693	69.00
69.01	06901	CARDIAC REHABILITATION	0.377682	285	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.239386	96,156	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1.321415	2,053,418	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.595666	582,301	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.256113	8,301,589	73.00
74.00	07400	RENAL DIALYSIS	0.385693	285,950	74.00
76.00	03330	ENDOSCOPY	0.134522	5,650	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.588938	210	90.00
91.00	09100	EMERGENCY	0.162974	3,421,864	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.015918	240,061	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		49,561,505	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)		49,561,505	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0034 Component CCN: 14-S034	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/28/2019 11:34 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		1,492,575		40.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.205410	0	0	50.00
51.00	05100 RECOVERY ROOM	0.142116	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.463058	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.122301	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.190281	13,910	2,647	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.264961	0	0	55.00
56.00	05600 RADIOISOTOPE	0.113356	3,525	400	56.00
57.00	05700 CT SCAN	0.027149	62,550	1,698	57.00
58.00	05800 MRI	0.067604	10,000	676	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.229672	0	0	59.00
60.00	06000 LABORATORY	0.125311	403,826	50,604	60.00
64.00	06400 INTRAVENOUS THERAPY	0.256878	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.179806	101,685	18,284	65.00
66.00	06600 PHYSICAL THERAPY	0.350956	11,135	3,908	66.00
66.01	06601 CLINICAL NUTRITION	5.145879	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.308679	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.574469	800	460	68.00
69.00	06900 ELECTROCARDIOLOGY	0.110711	27,476	3,042	69.00
69.01	06901 CARDIAC REHABILITATION	0.377682	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.239386	12,908	3,090	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	1.321415	7,000	9,250	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.595666	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.256113	117,070	29,983	73.00
74.00	07400 RENAL DIALYSIS	0.385693	5,320	2,052	74.00
76.00	03330 ENDOSCOPY	0.134522	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.588938	0	0	90.00
91.00	09100 EMERGENCY	0.162974	184,880	30,131	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	1.015918	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		962,085	156,225	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		962,085		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/28/2019 11:34 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS</b>				
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)		11,867,978	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		3,181,960	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)		213,040	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)		76.33	4.00
<b>Indirect Medical Education Adjustment</b>				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
<b>Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA</b>				
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
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.28	30.00
31.00	Percentage of Medicaid patient days (see instructions)		18.87	31.00
32.00	Sum of lines 30 and 31		23.15	32.00
33.00	Allowable disproportionate share percentage (see instructions)		8.31	33.00
34.00	Disproportionate share adjustment (see instructions)		312,662	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/28/2019 11:34 am
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
<b>Uncompensated Care Adjustment</b>				
35.00	Total uncompensated care amount (see instructions)	6,766,695,164	8,272,872,447	35.00
35.01	Factor 3 (see instructions)	0.000121679	0.000097481	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	823,363	806,445	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	615,830	203,268	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	819,098		36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)</b>				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	16,394,738		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	18,417,743		48.00
				<b>Amount</b>
				<b>1.00</b>
49.00	Total payment for inpatient operating costs (see instructions)		17,911,992	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,231,535	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)		19,143,527	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		19,143,527	61.00
62.00	Deductibles billed to program beneficiaries		2,081,880	62.00
63.00	Coinurance billed to program beneficiaries		29,815	63.00
64.00	Allowable bad debts (see instructions)		495,021	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		321,764	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		374,959	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		17,353,596	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		20,866	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		-27,051	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		207,912	70.93
70.94	HRR adjustment amount (see instructions)		-274,561	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/28/2019 11:34 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		17,280,762	71.00
71.01	Sequestration adjustment (see instructions)		345,615	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		17,146,623	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)		-211,476	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		780,778	75.00
<b>TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)</b>				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
			Prior to 10/1	On/After 10/1
			1.00	2.00
<b>HSP Bonus Payment Amount</b>				
100.00	HSP bonus amount (see instructions)		1,134,823	382,431
<b>HVBP Adjustment for HSP Bonus Payment</b>				
101.00	HVBP adjustment factor (see instructions)		1.0141365359	1.0126144634
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		16,042	4,824
<b>HRR Adjustment for HSP Bonus Payment</b>				
103.00	HRR adjustment factor (see instructions)		0.9796	0.9898
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		-23,150	-3,901
<b>Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment</b>				
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.			
<b>Cost Reimbursement</b>				
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
<b>Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)</b>				
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
<b>Adjustment to Medicare Part A Inpatient Reimbursement</b>				
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
<b>Comparison of PPS versus Cost Reimbursement</b>				
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: 14-0034

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

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
5/28/2019 11:34 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	11,867,978	0	11,867,978		11,867,978	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,181,960	0		3,181,960	3,181,960	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	213,040	0	195,186	17,854	213,040	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
<b>Indirect Medical Education Adjustment</b>								
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
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>								
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
<b>Disproportionate Share Adjustment</b>								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0831	0.0831	0.0831	0.0831		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	312,662	0	246,557	66,105	312,662	11.00
11.01	Uncompensated care payments	36.00	819,098	0	615,830	203,268	819,098	11.01
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	16,394,738	0	12,925,551	3,469,187	16,394,738	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	18,417,743	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	17,911,992	0	14,442,805	3,469,187	17,911,992	15.00
16.00	Payment for inpatient program capital (From Wkst. L, Pt. I, if applicable)	50.00	1,231,535	0	972,408	259,127	1,231,535	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition 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: 14-0034

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

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
5/28/2019 11:34 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	15,415,213	3,728,314	19,143,527	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	1,216,183	0	959,089	257,094	1,216,183	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	15,352	0	13,319	2,033	15,352	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	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	1,231,535	0	972,408	259,127	1,231,535	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: 14-0034		Period: From 01/01/2018 To 12/31/2018		Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/28/2019 11:34 am	
Title XVIII				Hospital		PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (col. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	11,867,978	11,867,978		11,867,978	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,181,960		3,181,960	3,181,960	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	213,040	195,186	17,854	213,040	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
<b>Indirect Medical Education Adjustment</b>							
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
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>							
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
<b>Disproportionate Share Adjustment</b>							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0831	0.0831	0.0831		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	312,662	246,557	66,105	312,662	11.00
11.01	Uncompensated care payments	36.00	819,098	615,830	203,268	819,098	11.01
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	16,394,738	12,925,551	3,469,187	16,394,738	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	18,417,743	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	17,911,992	14,442,805	3,469,187	17,911,992	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,231,535	972,408	259,127	1,231,535	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	<b>SUBTOTAL</b>			15,415,213	3,728,314	19,143,527	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/28/2019 11:34 am
		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	1,216,183	959,089	257,094	1,216,183	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	15,352	13,319	2,033	15,352	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	1,231,535	972,408	259,127	1,231,535	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	207,912	167,773	40,139	207,912	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	20,866	16,042	4,824	20,866	30.01
31.00	HRR adjustment (see instructions)	70.94	-274,561	-242,106	-32,455	-274,561	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	-27,051	-23,150	-3,901	-27,051	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: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/28/2019 11:34 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		47,345	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		11,344,507	2.00
3.00	OPPS payments		9,833,013	3.00
4.00	Outlier payment (see instructions)		37,900	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)		47,345	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		184,859	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)		184,859	14.00
<b>Customary charges</b>				
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)		184,859	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		137,514	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)		47,345	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)		9,870,913	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,973,336	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)		7,944,922	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)		7,944,922	30.00
31.00	Primary payer payments		631	31.00
32.00	Subtotal (line 30 minus line 31)		7,944,291	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		293,849	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		191,002	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		181,266	36.00
37.00	Subtotal (see instructions)		8,135,293	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		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)		8,135,293	40.00
40.01	Sequestration adjustment (see instructions)		162,706	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		8,021,328	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-48,741	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0034 Component CCN: 14-S034	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/28/2019 11:34 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)			0 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		195,030	2.00
3.00	OPPS payments		97,016	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		0	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)		0	14.00
<b>Customary charges</b>				
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)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	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)		97,016	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		22,817	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)		74,199	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)		74,199	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		74,199	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		74,199	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		74,199	40.00
40.01	Sequestration adjustment (see instructions)		1,484	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		72,717	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-2	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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: 14-0034		Period: From 01/01/2018 To 12/31/2018		Worksheet E-1 Part I Date/Time Prepared: 5/28/2019 11:34 am	
		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		16,752,827		7,781,703		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		306,799		142,162		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	07/16/2018	86,997	07/16/2018	97,463		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		86,997		97,463		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)		17,146,623		8,021,328		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		211,476		48,741		6.02
7.00	Total Medicare program liability (see instructions)		16,935,147		7,972,587		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0034  
Component CCN: 14-S034

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/28/2019 11:34 am

Title XVIII

Subprovider -  
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,103,840		72,717	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,103,840		72,717	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		42,574		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		2	6.02
7.00	Total Medicare program liability (see instructions)		1,146,414		72,715	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: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/28/2019 11:34 am
		Title XVIII	Hospital	PPS
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
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
<b>INPATIENT HOSPITAL SERVICES UNDER THE IPPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0034 Component CCN: 14-S034	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part II Date/Time Prepared: 5/28/2019 11:34 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
<b>PART II - MEDICARE PART A SERVICES - IPF PPS</b>				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			1,339,510 1.00
2.00	Net IPF PPS Outlier Payments			0 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			13.835616 9.00
10.00	Teaching Adjustment Factor $\{(1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1\}$ .			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			1,339,510 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			1,339,510 16.00
17.00	Primary payer payments			4,572 17.00
18.00	Subtotal (line 16 less line 17).			1,334,938 18.00
19.00	Deductibles			192,809 19.00
20.00	Subtotal (line 18 minus line 19)			1,142,129 20.00
21.00	Coinsurance			15,745 21.00
22.00	Subtotal (line 20 minus line 21)			1,126,384 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			66,809 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			43,426 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			56,371 25.00
26.00	Subtotal (sum of lines 22 and 24)			1,169,810 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			1,169,810 31.00
31.01	Sequestration adjustment (see instructions)			23,396 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			1,103,840 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			42,574 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

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

Provider CCN: 14-0034

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

Worksheet G

Date/Time Prepared:  
5/28/2019 11:34 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	223,994	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	19,287,482	0	0	0	4.00
5.00	Other receivable	-16,978	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,255,561	0	0	0	7.00
8.00	Prepaid expenses	595,259	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	22,345,318	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	1,259,000	0	0	0	12.00
13.00	Land improvements	667,527	0	0	0	13.00
14.00	Accumulated depreciation	-667,527	0	0	0	14.00
15.00	Buildings	37,885,461	0	0	0	15.00
16.00	Accumulated depreciation	-15,119,488	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	4,821,267	0	0	0	19.00
20.00	Accumulated depreciation	-2,010,756	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	29,053,968	0	0	0	23.00
24.00	Accumulated depreciation	-19,344,365	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	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	36,545,087	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	1,855,332	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	589,334	680,357	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,444,666	680,357	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	61,335,071	680,357	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	3,004,502	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,919,358	0	0	0	38.00
39.00	Payroll taxes payable	106,395	0	0	0	39.00
40.00	Notes and loans payable (short term)	546,771	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	0	0	0	0	43.00
44.00	Other current liabilities	7,515,934	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	15,092,960	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	44,678,000	0	0	0	47.00
48.00	Unsecured loans	8,769,866	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	53,447,866	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	68,540,826	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	-7,205,755				52.00
53.00	Specific purpose fund		680,357			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)	-7,205,755	680,357	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	61,335,071	680,357	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0034

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

Worksheet G-1

Date/Time Prepared:  
5/28/2019 11:34 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-19,653,565		137,946		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		14,432,930				2.00
3.00	Total (sum of line 1 and line 2)		-5,220,635		137,946		3.00
4.00	CREDIT ADJUSTMENTS	258,227		544,531		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00	TRANSFER FROM OTHER RELATED	7,545		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)		265,772		544,531		10.00
11.00	Subtotal (line 3 plus line 10)		-4,954,863		682,477		11.00
12.00	DEDUCTIONS	2,250,892		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	TRANSFER TO OTHER FUNDS	0		2,120		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		2,250,892		2,120		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-7,205,755		680,357		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	CREDIT ADJUSTMENTS		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00	TRANSFER FROM OTHER RELATED		0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	DEDUCTIONS		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00	TRANSFER TO OTHER FUNDS		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: 14-0034

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/28/2019 11:34 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	30,899,104		30,899,104	1.00
2.00	SUBPROVIDER - IPF	5,905,576		5,905,576	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)	36,804,680		36,804,680	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	-5,320,575		-5,320,575	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	-5,320,575		-5,320,575	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	31,484,105		31,484,105	17.00
18.00	Ancillary services	77,855,529	139,675,432	217,530,961	18.00
19.00	Outpatient services	5,213,420	52,366,336	57,579,756	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
24.20	OPT	0	0	0	24.20
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NON-REIMBURSABLE PROFESSIONAL FEES	4,436,379	6,398,315	10,834,694	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	118,989,433	198,440,083	317,429,516	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		95,668,404		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)		95,668,404		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0034

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

Worksheet G-3

Date/Time Prepared:  
5/28/2019 11:34 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	317,429,516	1.00
2.00	Less contractual allowances and discounts on patients' accounts	209,732,127	2.00
3.00	Net patient revenues (line 1 minus line 2)	107,697,389	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	95,668,404	4.00
5.00	Net income from service to patients (line 3 minus line 4)	12,028,985	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	-249,040	6.00
7.00	Income from investments	654,916	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	1,829	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	254,480	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	1,164	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	8,729	21.00
22.00	Rental of hospital space	312,008	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	1,419,859	24.00
25.00	Total other income (sum of lines 6-24)	2,403,945	25.00
26.00	Total (line 5 plus line 25)	14,432,930	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	14,432,930	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0034	Period: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III Date/Time Prepared: 5/28/2019 11:34 am
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		1,216,183	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		15,352	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)		38.64	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)		1,231,535	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
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
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
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