

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: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/28/2019 11:42 am
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PART I - COST REPORT STATUS

Provider use only 1. Electronically filed cost report Date: 5/28/2019 Time: 11:42 am
 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 6. Date Received: 10. NPR Date:
 (1) As Submitted 7. Contractor No. 11. Contractor's Vendor Code: 4
 (2) Settled without Audit 8. Initial Report for this Provider CCN 12. If line 5, column 1 is 4: Enter
 (3) Settled with Audit 9. Final Report for this Provider CCN number of times reopened = 0-9.
 (4) Reopened
 (5) Amended

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 GOOD SAMARITAN HOSPITAL (14-0046) 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 VICE PRESIDENT - 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	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-74,435	178,591	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	-75,670	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0	0	0		0	6.00
200.00 Total	0	-150,105	178,591	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0046		Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 11:42 am				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 1 GOOD SAMARITAN WAY			PO Box:							1.00	
2.00	City: MT. VERNON			State: IL		Zip Code: 62864		County: JEFFERSON			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		
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		SSM HEALTH GOOD SAMARITAN HOSPITAL		140046	99914	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF		GOOD SAMARITAN REHABILITATION UNIT		14T046	99914	5	01/01/1990	N	P	P	5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF											7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:	To:				
							1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2018	12/31/2018		20.00		
21.00	Type of Control (see instructions)						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		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.											
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		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
				1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			2,761	452	0	7	3,079	267		24.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0046			Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 11:42 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		
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.	32	18	0	0	7		25.00	
						Urban/Rural	Date of Geogr		
						1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00	
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPSS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00	
						V	XVII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification 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

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

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

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						1.00			
Long Term Care Hospital PPS									
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N				80.00		
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N				81.00		
TEFRA Providers									
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N				85.00		
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						86.00		
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N				87.00		
						V	XIX		
						1.00	2.00		
Title V and XIX Services									
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N		Y		90.00		
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N		N		91.00		
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N		92.00		
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N		N		93.00		
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N		N		94.00		
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00			0.00		95.00		
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N		N		96.00		
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00			0.00		97.00		
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y		Y		98.00		
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y		Y		98.01		
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y		Y		98.02		
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N		N		98.03		
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N		N		98.04		
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y		Y		98.05		
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y		Y		98.06		
Rural Providers									
105.00	Does this hospital qualify as a CAH?		N				105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)						106.00		
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.						107.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N				108.00		
						Physical	Occupational	Speech	Respiratory
						1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N		N		N		N
						1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N				110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 11:42 am		
		1.00	2.00			
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00
		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	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:	4,044,920	198	0		
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		269020		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 11:42 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: BRIAN SCHMEIDLER	Contractor's Name: A		Contractor's Number: 05301			
142.00	Street: 1195 CORPORATE LAKE DRIVE	PO Box:					
143.00	City: ST. LOUIS	State: MO		Zip Code: 63132			
144.00 Are provider based physicians' costs included in Worksheet A?							
				1.00	2.00		
				Y			
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.							
				1.00	2.00		
				Y			
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.							
				1.00	2.00		
				N			
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							
				1.00	2.00		
				N			
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							
				1.00	2.00		
				N			
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							
				1.00	2.00		
				N			
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)							
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
155.00	Hospital	N	N	N	N		
156.00	Subprovider - IPF	N	N	N	N		
157.00	Subprovider - IRF	N	N	N	N		
158.00	SUBPROVIDER						
159.00	SNF	N	N	N	N		
160.00	HOME HEALTH AGENCY	N	N	N	N		
161.00	CMHC		N	N	N		
Multi campus							
165.00 Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							
				1.00	2.00		
				N			
		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
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.							
				1.00	2.00		
				Y			
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)							
				1.00	2.00		
				0			
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)							
				1.00	2.00		
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)							
				1.00	2.00		
				9.99			
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							
				1.00	2.00		
				09/30/2018	12/28/2018		
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)							
				1.00	2.00		
				N			
					0		

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0046		Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part II Date/Time Prepared: 5/28/2019 11:42 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.	Y					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					1.00
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.				Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				N		14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				N		15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	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	03/28/2018	Y	03/28/2018		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: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/28/2019 11:42 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	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		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	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/28/2019 11:42 am
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER - GOVERNMENT 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: 14-0046

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

Worksheet S-3
Part I
Date/Time Prepared:
5/28/2019 11:42 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	109	39,785	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)		109	39,785	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	15	5,475	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)		124	45,260	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	10	3,650		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		134				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: 14-0046

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

Worksheet S-3
Part I
Date/Time Prepared:
5/28/2019 11:42 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents			
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll		
	6.00	7.00	8.00	9.00	10.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	13,223	1,569	23,961			1.00
2.00	HMO and other (see instructions)	1,834	3,538				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	13,223	1,569	23,961			7.00
8.00	INTENSIVE CARE UNIT	1,362	387	2,392			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		805	2,063			13.00
14.00	Total (see instructions)	14,585	2,761	28,416	0.00	723.96	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	1,240	55	1,549	0.00	9.55	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	733.51	27.00
28.00	Observation Bed Days		262	1,906			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			457			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	267	441			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: 14-0046

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

Worksheet S-3
Part I
Date/Time Prepared:
5/28/2019 11:42 am

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	3,345	1,723	11,782	1.00
2.00 HMO and other (see instructions)			394	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	3,345	1,723	11,782	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	120	5	162	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 14-0046		Period: From 01/01/2018 To 12/31/2018		Worksheet S-3 Part II Date/Time Prepared: 5/28/2019 11:42 am	
	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	53,840,523	0	53,840,523	1,811,315.07	29.72	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		155,108	0	155,108	994.00	156.04	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		1,759,064	-213,280	1,545,784	20,650.74	74.85	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract Labor: Direct Patient Care		687,902	0	687,902	9,238.78	74.46	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract Labor: Physician-Part A - Administrative		412,839	0	412,839	3,484.00	118.50	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		7,270,720	0	7,270,720	203,551.87	35.72	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		22,402,781	0	22,402,781			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		216,450	0	216,450			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		27,116	0	27,116			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		115,621	0	115,621			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		2,574,405	0	2,574,405			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	204,800	192,436	397,236	8,637.01	45.99	26.00
27.00	Administrative & General	5.00	3,991,541	0	3,991,541	112,530.90	35.47	27.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0046

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

Worksheet S-3
Part II
Date/Time Prepared:
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		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.)		294,930	0	294,930	1,005.00	293.46	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	890,854	0	890,854	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	110,794	0	110,794	39,950.79	2.77	31.00
32.00	Housekeeping	9.00	1,447,161	0	1,447,161	7,632.19	189.61	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,271,151	-924,194	346,957	103,732.76	3.34	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	924,194	924,194	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	824,332	0	824,332	31,305.00	26.33	38.00
39.00	Central Services and Supply	14.00	363,485	-242,540	120,945	20,902.47	5.79	39.00
40.00	Pharmacy	15.00	2,035,789	0	2,035,789	4,153.02	490.19	40.00
41.00	Medical Records & Medical Records Library	16.00	703,786	0	703,786	51,513.54	13.66	41.00
42.00	Social Service	17.00	1,149,066	0	1,149,066	33,850.35	33.95	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0046

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

Worksheet S-3
Part III
Date/Time Prepared:
5/28/2019 11:42 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	54,135,453	0	54,135,453	1,812,320.07	29.87	1.00
2.00	Excluded area salaries (see instructions)	1,759,064	-213,280	1,545,784	20,650.74	74.85	2.00
3.00	Subtotal salaries (line 1 minus line 2)	52,376,389	213,280	52,589,669	1,791,669.33	29.35	3.00
4.00	Subtotal other wages & related costs (see inst.)	8,371,461	0	8,371,461	216,274.65	38.71	4.00
5.00	Subtotal wage-related costs (see inst.)	25,004,302	0	25,004,302	0.00	47.55	5.00
6.00	Total (sum of lines 3 thru 5)	85,752,152	213,280	85,965,432	2,007,943.98	42.81	6.00
7.00	Total overhead cost (see instructions)	13,287,689	-50,104	13,237,585	415,213.03	31.88	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part IV Date/Time Prepared: 5/28/2019 11:42 am
			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		1,822,097	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)		3,269,000	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		11,206,607	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		630,877	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		230,324	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)		292,589	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		472,812	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		3,776,730	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		209,293	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		534,979	21.00
22.00	Day Care Cost and Allowances		316,660	22.00
23.00	Tuition Reimbursement		0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		22,761,968	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part V Date/Time Prepared: 5/28/2019 11:42 am
Cost Center Description			Contract Labor	Benefit Cost
			1.00	2.00
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		687,902	22,761,968
2.00	Hospital		687,902	22,545,518
3.00	Subprovider - IPF			
4.00	Subprovider - IRF		0	3,010
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			
17.00	Renal Dialysis		0	0
18.00	Other		0	213,440

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet S-10 Date/Time Prepared: 5/28/2019 11:42 am
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.251428	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		13,705,377	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		2,746,815	5.00	
6.00	Medicaid charges		118,250,818	6.00	
7.00	Medicaid cost (line 1 times line 6)		29,731,567	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)		13,279,375	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		0	9.00	
10.00	Stand-alone CHIP charges		0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		13,279,375	19.00	
			Uninsured patients	Insured patients	Total (col. 1 + col. 2)
			1.00	2.00	3.00
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	5,282,830	2,636,986	7,919,816	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,328,251	2,636,986	3,965,237	21.00
22.00	Payments received from patients for amounts previously written off as charity care	27,714	308,278	335,992	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,300,537	2,328,708	3,629,245	23.00
			1.00		
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			7,456,939	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			891,511	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			1,371,555	27.01
28.00	Non-Medicare bad debt expense (see instructions)			6,085,384	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			2,010,080	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			5,639,325	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			18,918,700	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 14-0046		Period: From 01/01/2018 To 12/31/2018		Worksheet A		
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)		
		1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		14,769,372	14,769,372	1,220,945	15,990,317	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		4,213,380	4,213,380	0	4,213,380	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	204,800	22,537,608	22,742,408	222,878	22,965,286	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,991,541	27,045,741	31,037,282	563,202	31,600,484	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	890,854	4,576,762	5,467,616	417,060	5,884,676	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	110,794	499,698	610,492	0	610,492	8.00
9.00	00900	HOUSEKEEPING	1,447,161	659,176	2,106,337	-259,156	1,847,181	9.00
10.00	01000	DIETARY	1,271,151	918,600	2,189,751	-1,580,607	609,144	10.00
11.00	01100	CAFETERIA	0	0	0	1,589,207	1,589,207	11.00
13.00	01300	NURSING ADMINISTRATION	824,332	93,221	917,553	0	917,553	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	363,485	304,443	667,928	-298,759	369,169	14.00
15.00	01500	PHARMACY	2,035,789	16,299,075	18,334,864	-15,681,760	2,653,104	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	703,786	190,536	894,322	-333	893,989	16.00
17.00	01700	SOCIAL SERVICE	1,149,066	276,957	1,426,023	-74	1,425,949	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,284,070	2,407,883	16,691,953	-235,297	16,456,656	30.00
31.00	03100	INTENSIVE CARE UNIT	1,985,920	645,518	2,631,438	-554,507	2,076,931	31.00
41.00	04100	SUBPROVIDER - IIRF	748,739	19,883	768,622	-28,703	739,919	41.00
43.00	04300	NURSERY	0	0	0	460,852	460,852	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,135,452	9,744,549	12,880,001	-7,240,773	5,639,228	50.00
51.00	05100	RECOVERY ROOM	396,308	40,687	436,995	-38,077	398,918	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,622,391	487,086	3,109,477	-1,343,403	1,766,074	52.00
53.00	05300	ANESTHESIOLOGY	28,415	5,824,976	5,853,391	-253,234	5,600,157	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,451,252	261,734	1,712,986	-119,751	1,593,235	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	713,467	612,158	1,325,625	-462,659	862,966	55.00
56.00	05600	RADIOISOTOPE	225,237	290,367	515,604	-13,946	501,658	56.00
57.00	05700	CT SCAN	519,539	136,194	655,733	-65,462	590,271	57.00
58.00	05800	MRI	193,576	51,458	245,034	-39,535	205,499	58.00
59.00	05900	CARDIAC CATHETERIZATION	737,337	3,428,288	4,165,625	-3,252,891	912,734	59.00
60.00	06000	LABORATORY	2,253,269	3,380,203	5,633,472	-144,560	5,488,912	60.00
64.00	06400	INTRAVENOUS THERAPY	253,731	29,627	283,358	-22,404	260,954	64.00
65.00	06500	RESPIRATORY THERAPY	1,244,725	433,832	1,678,557	-265,371	1,413,186	65.00
66.00	06600	PHYSICAL THERAPY	1,170,858	22,407	1,193,265	-8,323	1,184,942	66.00
66.01	06601	CLINICAL NUTRITION	185,475	395	185,870	0	185,870	66.01
67.00	06700	OCCUPATIONAL THERAPY	445,593	7,594	453,187	-3,785	449,402	67.00
68.00	06800	SPEECH PATHOLOGY	268,266	7,706	275,972	-2,294	273,678	68.00
69.00	06900	ELECTROCARDIOLOGY	464,799	1,018,403	1,483,202	-22,119	1,461,083	69.00
69.01	06901	CARDIAC REHABILITATION	180,342	23,196	203,538	-1,572	201,966	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	57,874	13,762	71,636	0	71,636	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	8,900,337	8,900,337	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	5,656,423	5,656,423	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,254,275	153,364	1,407,639	15,936,775	17,344,414	73.00
74.00	07400	RENAL DIALYSIS	61,071	428,451	489,522	-10,708	478,814	74.00
76.00	03950	ACUTE DIALYSIS	130,734	175,417	306,151	-159,363	146,788	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,167,590	2,668,873	4,836,463	-397,206	4,439,257	90.00
91.00	09100	EMERGENCY	2,657,134	1,597,494	4,254,628	-387,326	3,867,302	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	52,830,198	126,296,074	179,126,272	2,073,721	181,199,993	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	63,275	9,369	72,644	0	72,644	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	438,050	-292,516	145,534	0	145,534	192.00
194.00	07950	NON-REIMBURSABLE	509,000	2,799,977	3,308,977	-2,073,721	1,235,256	194.00
194.01	07951	CONTRACT PHARMACY	0	745,517	745,517	0	745,517	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	53,840,523	129,558,421	183,398,944	0	183,398,944	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0046

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

Worksheet A
Date/Time Prepared:
5/28/2019 11:42 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-6,125,640	9,864,677	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,074,037	5,287,417	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-6,150,756	16,814,530	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-5,355,265	26,245,219	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-734,802	5,149,874	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	610,492	8.00
9.00	00900	HOUSEKEEPING	-32	1,847,149	9.00
10.00	01000	DIETARY	0	609,144	10.00
11.00	01100	CAFETERIA	-728,664	860,543	11.00
13.00	01300	NURSING ADMINISTRATION	-210	917,343	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	369,169	14.00
15.00	01500	PHARMACY	-50,842	2,602,262	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-49,222	844,767	16.00
17.00	01700	SOCIAL SERVICE	-29,088	1,396,861	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-6,178,767	10,277,889	30.00
31.00	03100	INTENSIVE CARE UNIT	-9,779	2,067,152	31.00
41.00	04100	SUBPROVIDER - IRF	-12,510	727,409	41.00
43.00	04300	NURSERY	0	460,852	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-674,769	4,964,459	50.00
51.00	05100	RECOVERY ROOM	0	398,918	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,766,074	52.00
53.00	05300	ANESTHESIOLOGY	-5,344,426	255,731	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,616	1,591,619	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	-123,958	739,008	55.00
56.00	05600	RADIOISOTOPE	0	501,658	56.00
57.00	05700	CT SCAN	0	590,271	57.00
58.00	05800	MRI	0	205,499	58.00
59.00	05900	CARDIAC CATHETERIZATION	-34	912,700	59.00
60.00	06000	LABORATORY	-39,831	5,449,081	60.00
64.00	06400	INTRAVENOUS THERAPY	0	260,954	64.00
65.00	06500	RESPIRATORY THERAPY	-38,135	1,375,051	65.00
66.00	06600	PHYSICAL THERAPY	0	1,184,942	66.00
66.01	06601	CLINICAL NUTRITION	0	185,870	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	449,402	67.00
68.00	06800	SPEECH PATHOLOGY	0	273,678	68.00
69.00	06900	ELECTROCARDIOLOGY	-806,024	655,059	69.00
69.01	06901	CARDIAC REHABILITATION	-32,426	169,540	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	-2,364	69,272	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	-283,990	8,616,347	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	5,656,423	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-2,152	17,342,262	73.00
74.00	07400	RENAL DIALYSIS	-41,096	437,718	74.00
76.00	03950	ACUTE DIALYSIS	0	146,788	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-6,564	4,432,693	90.00
91.00	09100	EMERGENCY	-1,067,954	2,799,348	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-32,816,879	148,383,114	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	72,644	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	145,534	192.00
194.00	07950	NON-REIMBURSABLE	0	1,235,256	194.00
194.01	07951	CONTRACT PHARMACY	0	745,517	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-32,816,879	150,582,065	200.00

RECLASSIFICATIONS

Provider CCN: 14-0046

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

Worksheet A-6

Date/Time Prepared:
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		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - OBSTETRICS UNIT COST					
1.00	ADULTS & PEDIATRICS	30.00	510,081	99,947	1.00
2.00	NURSERY	43.00	388,661	72,191	2.00
3.00		0.00	0	0	3.00
	O		898,742	172,138	
B - UTILITIES EXPENSES RECLASS					
1.00	OPERATION OF PLANT	7.00	0	417,060	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
	TOTALS		0	417,060	
C - CENTRAL SERVICE SUPPLY RECLASS					
1.00	OPERATING ROOM	50.00	60,148	6,669	1.00
2.00	RECOVERY ROOM	51.00	54	6	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	1,065	118	3.00
4.00	RADIOLOGY - THERAPEUTIC	55.00	5,452	604	4.00
5.00	CT SCAN	57.00	311	34	5.00
6.00	CARDIAC CATHETERIZATION	59.00	149,839	16,613	6.00
7.00	RESPIRATORY THERAPY	65.00	25,456	2,822	7.00
8.00	SPEECH PATHOLOGY	68.00	20	2	8.00
9.00	DRUGS CHARGED TO PATIENTS	73.00	37	4	9.00
10.00	CLINIC	90.00	134	15	10.00
11.00	EMERGENCY	91.00	14	2	11.00
12.00	ELECTROCARDIOLOGY	69.00	3	0	12.00
13.00	ADULTS & PEDIATRICS	30.00	4	0	13.00
14.00	SUBPROVIDER - IRF	41.00	3	0	14.00
	TOTALS		242,540	26,889	
E - SHARED DIETARY COST					
1.00	CAFETERIA	11.00	924,194	665,013	1.00
	O		924,194	665,013	
G - CHILD CARE DIETARY					
1.00	DIETARY	10.00	0	8,600	1.00
	O		0	8,600	
H - EMPLOYEE CHILD CARE					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	192,436	30,442	1.00
	O		192,436	30,442	
I - IV PUMP COST					
1.00	ADULTS & PEDIATRICS	30.00	0	14,988	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	18	2.00
3.00	LABORATORY	60.00	0	2	3.00
4.00	INTRAVENOUS THERAPY	64.00	0	4,086	4.00
5.00	DRUGS CHARGED TO PATIENTS	73.00	0	67	5.00
6.00	CLINIC	90.00	0	5,227	6.00
7.00	EMERGENCY	91.00	0	4,942	7.00
	TOTALS		0	29,330	
L - MEDICAL PLAZA EXPENSES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,243,424	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	621,298	2.00
	O		0	1,864,722	
M - CHILD CARE DEPRECIATION					
1.00	NON-REIMBURSABLE	194.00	0	22,479	1.00
	O		0	22,479	
N - C. SUPPLIES-CHARGE MED SUPPL & DEVIC					
1.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	8,900,337	1.00
2.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00	0	5,656,423	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

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
0			0	14,556,760		
0 - PHARMACY						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	16,060,446		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
0			0	16,060,446		
500.00	Grand Total: Increases		2,257,912	33,853,879		500.00

RECLASSIFICATIONS

Provider CCN: 14-0046

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

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Date/Time Prepared:
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Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
A - OBSTETRICS UNIT COST						
1.00	INTENSIVE CARE UNIT	31.00	60,369	19,736	0	1.00
2.00	SUBPROVIDER - IRF	41.00	20,847	554	0	2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	817,526	151,848	0	3.00
	TOTALS		898,742	172,138		
B - UTILITIES EXPENSES RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	58,096	0	1.00
2.00	HOUSEKEEPING	9.00	0	259,156	0	2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	0	333	0	3.00
4.00	SOCIAL SERVICE	17.00	0	74	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	0	2,144	0	5.00
6.00	INTENSIVE CARE UNIT	31.00	0	114	0	6.00
7.00	SUBPROVIDER - IRF	41.00	0	128	0	7.00
8.00	OPERATING ROOM	50.00	0	634	0	8.00
9.00	ANESTHESIOLOGY	53.00	0	48	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,943	0	10.00
11.00	RADIOLOGY - THERAPEUTIC	55.00	0	2,232	0	11.00
12.00	LABORATORY	60.00	0	32	0	12.00
13.00	CLINIC	90.00	0	89,879	0	13.00
14.00	EMERGENCY	91.00	0	1,247	0	14.00
	TOTALS		0	417,060		
C - CENTRAL SERVICE SUPPLY RECLASS						
1.00	CENTRAL SERVICE & SUPPLY	14.00	242,540	26,889	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00
13.00		0.00	0	0	0	13.00
14.00		0.00	0	0	0	14.00
	TOTALS		242,540	26,889		
E - SHARED DIETARY COST						
1.00	DIETARY	10.00	924,194	665,013	0	1.00
	TOTALS		924,194	665,013		
G - CHILD CARE DIETARY						
1.00	NON-REIMBURSABLE	194.00	0	8,600	0	1.00
	TOTALS		0	8,600		
H - EMPLOYEE CHILD CARE						
1.00	NON-REIMBURSABLE	194.00	192,436	30,442	0	1.00
	TOTALS		192,436	30,442		
I - IV PUMP COST						
1.00	CENTRAL SERVICE & SUPPLY	14.00	0	29,330	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
	TOTALS		0	29,330		
L - MEDICAL PLAZA EXPENSES						
1.00	NON-REIMBURSABLE	194.00	0	1,864,722	10	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		0	1,864,722		
M - CHILD CARE DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	22,479	9	1.00
	TOTALS		0	22,479		
N - C. SUPPLIES-CHARGE MED SUPPL & DEVIC						
1.00	ADULTS & PEDIATRICS	30.00	0	858,173	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	474,306	0	2.00
3.00	SUBPROVIDER - IRF	41.00	0	7,177	0	3.00
4.00	OPERATING ROOM	50.00	0	7,287,061	0	4.00
5.00	RECOVERY ROOM	51.00	0	38,137	0	5.00
6.00	DELIVERY ROOM & LABOR ROOM	52.00	0	374,029	0	6.00
7.00	ANESTHESIOLOGY	53.00	0	253,186	0	7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	117,991	0	8.00
9.00	RADIOLOGY - THERAPEUTIC	55.00	0	166,322	0	9.00
10.00	RADIOISOTOPE	56.00	0	13,946	0	10.00
11.00	CT SCAN	57.00	0	65,807	0	11.00

RECLASSIFICATIONS

Provider CCN: 14-0046

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

Worksheet A-6

Date/Time Prepared:
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Decreases							
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
6.00	7.00	8.00	9.00	10.00			
12.00	MRI	58.00	0	39,535	0	12.00	
13.00	CARDIAC CATHETERIZATION	59.00	0	3,419,343	0	13.00	
14.00	LABORATORY	60.00	0	144,530	0	14.00	
15.00	INTRAVENOUS THERAPY	64.00	0	26,490	0	15.00	
16.00	RESPIRATORY THERAPY	65.00	0	293,649	0	16.00	
17.00	PHYSICAL THERAPY	66.00	0	8,323	0	17.00	
18.00	OCCUPATIONAL THERAPY	67.00	0	3,785	0	18.00	
19.00	SPEECH PATHOLOGY	68.00	0	2,316	0	19.00	
20.00	ELECTROCARDIOLOGY	69.00	0	22,122	0	20.00	
21.00	CARDIAC REHABILITATION	69.01	0	1,572	0	21.00	
22.00	DRUGS CHARGED TO PATIENTS	73.00	0	123,779	0	22.00	
23.00	RENAL DIALYSIS	74.00	0	10,708	0	23.00	
24.00	ACUTE DIALYSIS	76.00	0	159,363	0	24.00	
25.00	CLINIC	90.00	0	254,073	0	25.00	
26.00	EMERGENCY	91.00	0	391,037	0	26.00	
	O		0	14,556,760			
O - PHARMACY							
1.00	PHARMACY	15.00	0	15,681,760	0	1.00	
2.00	OPERATING ROOM	50.00	0	19,895	0	2.00	
3.00	RADIOLOGY - THERAPEUTIC	55.00	0	300,161	0	3.00	
4.00	CLINIC	90.00	0	58,630	0	4.00	
	O		0	16,060,446			
500.00	Grand Total: Decreases		2,257,912	33,853,879		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0046

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

Worksheet A-7
Part I
Date/Time Prepared:
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	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	632,759	0	0	0	1.00
2.00	Land Improvements	6,642,350	693,782	0	693,782	2.00
3.00	Buildings and Fixtures	158,566,850	109,755	0	109,755	3.00
4.00	Building Improvements	17,657,246	7,269	0	7,269	4.00
5.00	Fixed Equipment	15,130,530	240,428	0	240,428	5.00
6.00	Movable Equipment	60,548,475	2,820,963	0	2,820,963	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	259,178,210	3,872,197	0	3,872,197	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	259,178,210	3,872,197	0	3,872,197	10.00
	Ending Balance		Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	632,759	0			1.00
2.00	Land Improvements	7,336,132	0			2.00
3.00	Buildings and Fixtures	158,676,605	0			3.00
4.00	Building Improvements	17,664,515	0			4.00
5.00	Fixed Equipment	15,370,958	0			5.00
6.00	Movable Equipment	62,986,275	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	262,667,244	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	262,667,244	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0046

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

Worksheet A-7
Part II
Date/Time Prepared:
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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	8,430,632	0	6,338,740	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,213,380	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	12,644,012	0	6,338,740	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	14,769,372				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4,213,380				2.00
3.00	Total (sum of lines 1-2)	0	18,982,752				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CCN: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet A-7 Part III Date/Time Prepared: 5/28/2019 11:42 am
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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	199,680,968	13,205,798	186,475,170	0.746365	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	63,369,437	0	63,369,437	0.253635	0	2.00
3.00	Total (sum of lines 1-2)	263,050,405	13,205,798	249,844,607	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	8,621,253	1,243,424	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	5,287,417	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	13,908,670	1,243,424	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	9,864,677	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	5,287,417	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	15,152,094	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0046

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

Worksheet A-8

Date/Time Prepared:
5/28/2019 11:42 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-38,836		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	-14,243,229				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)	B		0	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-16,163,706				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-728,664		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	B	-50,842		PHARMACY	15.00	0	17.00
18.00 Sale of medical records and abstracts	B	-49,222		MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines	B		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	B	-12,648		CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	B	-33,316		CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00 MISC REV	B	-99,003		ADMINISTRATIVE & GENERAL	5.00	0	33.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.	
			Cost Center		Line #		
			1.00	2.00	3.00		4.00
34.00	MI SC REV	B	-62,802	OPERATION OF PLANT	7.00	0	34.00
35.00	MI SC REV	B	-389,098	ADULTS & PEDIATRICS	30.00	0	35.00
36.00	MI SC REV	B	-38	INTENSIVE CARE UNIT	31.00	0	36.00
36.50	MI SC REV	B	-3,500	OPERATING ROOM	50.00	0	36.50
37.00	MI SC REV	B	-1,193	ANESTHESIOLOGY	53.00	0	37.00
39.00	MI SC REV	B	-20	RADIOLOGY-DIAGNOSTIC	54.00	0	39.00
40.00	MI SC REV	B	-104,659	RADIOLOGY - THERAPEUTIC	55.00	0	40.00
40.05	MI SC REV	B	-16,299	RESPIRATORY THERAPY	65.00	0	40.05
41.00	MI S REV	B	-18,848	CARDIAC REHABILITATION	69.01	0	41.00
41.01	MI SC REV	B	-9,488	EMERGENCY	91.00	0	41.01
41.20	ADVERTISING	A	-2,036	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	41.20
41.40	ADVERTISING	A	-28,801	ADMINISTRATIVE & GENERAL	5.00	0	41.40
44.00	ADVERTISING	A	-96	SOCIAL SERVICE	17.00	0	44.00
45.01	ADVERTISING	A	-474	ADULTS & PEDIATRICS	30.00	0	45.01
45.02	ADVERTISING	A	-630	OPERATING ROOM	50.00	0	45.02
45.03	ADVERTISING	A	-798	RADIOLOGY-DIAGNOSTIC	54.00	0	45.03
45.04	ADVERTISING	A	-1,070	DRUGS CHARGED TO PATIENTS	73.00	0	45.04
45.05	ADVERTISING	A	-2,955	CLINIC	90.00	0	45.05
45.07	ADVERTISING	A	-517	EMERGENCY	91.00	0	45.07
45.08	LOBBYING DUES	A	-5,727	ADMINISTRATIVE & GENERAL	5.00	0	45.08
45.09	MGMT - CLAY	A	-262,004	ADMINISTRATIVE & GENERAL	5.00	0	45.09
45.10	GIFTS & ENTERTAINMENT	A	-68,741	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.10
45.11	GIFTS & ENTERTAINMENT	A	-51,357	ADMINISTRATIVE & GENERAL	5.00	0	45.11
45.12	GIFTS & ENTERTAINMENT	A	-32	HOUSEKEEPING	9.00	0	45.12
45.13	GIFTS & ENTERTAINMENT	A	-210	NURSING ADMINISTRATION	13.00	0	45.13
45.15	GIFTS & ENTERTAINMENT	A	-223	ADULTS & PEDIATRICS	30.00	0	45.15
45.16	GIFTS & ENTERTAINMENT	A	-449	INTENSIVE CARE UNIT	31.00	0	45.16
45.17	GIFTS & ENTERTAINMENT	A	-13	OPERATING ROOM	50.00	0	45.17
45.18	GIFTS & ENTERTAINMENT	A	-34	CARDIAC CATHETERIZATION	59.00	0	45.18
45.21	GIFTS & ENTERTAINMENT	A	-106	LABORATORY	60.00	0	45.21
45.22	GIFTS & ENTERTAINMENT	A	-36	RESPIRATORY THERAPY	65.00	0	45.22
45.23	GIFTS & ENTERTAINMENT	A	-34	ELECTROCARDIOLOGY	69.00	0	45.23
45.24	GIFTS & ENTERTAINMENT	A	-12	DRUGS CHARGED TO PATIENTS	73.00	0	45.24
45.25	GIFTS & ENTERTAINMENT	A	-654	CLINIC	90.00	0	45.25
45.26	GIFTS & ENTERTAINMENT	A	-565	EMERGENCY	91.00	0	45.26
45.27	ADVERTISING	A	-2,036	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.27
45.28	ADVERTISING	A	-28,801	ADMINISTRATIVE & GENERAL	5.00	0	45.28
45.29	ADVERTISING	A	-96	SOCIAL SERVICE	17.00	0	45.29
45.32	ADVERTISING	A	-474	ADULTS & PEDIATRICS	30.00	0	45.32
45.33	ADVERTISING	A	-630	OPERATING ROOM	50.00	0	45.33
45.34	MD RECRUITMENT	A	-182,099	ADMINISTRATIVE & GENERAL	5.00	0	45.34
45.35	MD RECRUITMENT	A	-144,418	ADULTS & PEDIATRICS	30.00	0	45.35
45.36	ADVERTISING	A	-798	RADIOLOGY-DIAGNOSTIC	54.00	0	45.36
45.75	ADVERTISING	A	-1,070	DRUGS CHARGED TO PATIENTS	73.00	0	45.75
45.76	ADVERTISING	A	-2,955	CLINIC	90.00	0	45.76
45.77	ADVERTISING	A	-517	EMERGENCY	91.00	0	45.77
46.00	ADVERTISING	A	0		0.00	0	46.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-32,816,879				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: 14-0046

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

Worksheet A-8-1

Date/Time Prepared:
5/28/2019 11:42 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	225,748	0
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	1,107,353	0
3.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE - INTEREST	0	6,338,740
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	12,816,275	18,894,218
4.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	13,843,584	17,967,718
4.02	7.00	OPERATION OF PLANT	HOME OFFICE	0	672,000
4.03	71.00	MEDICAL SUPPLIES CHARGED TO	HOME OFFICE	-283,990	0
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			27,708,970	43,872,676

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

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

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

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

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

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

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

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

Provider CCN: 14-0046

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

Worksheet A-8-1

Date/Time Prepared:
5/28/2019 11:42 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	225,748	9		1.00
2.00	1,107,353	9		2.00
3.00	-6,338,740	11		3.00
4.00	-6,077,943	0		4.00
4.01	-4,124,134	0		4.01
4.02	-672,000	0		4.02
4.03	-283,990	0		4.03
5.00	-16,163,706			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0046

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

Worksheet A-8-2

Date/Time Prepared:
5/28/2019 11:42 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	611,868	456,217	155,651	159,800	1,007	1.00
2.00	17.00	SOCIAL SERVICE	28,896	28,896	0	159,800	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	5,663,594	5,616,696	46,898	159,800	254	3.00
4.00	31.00	INTENSIVE CARE UNIT	18,281	0	18,281	159,800	117	4.00
5.00	41.00	SUBPROVIDER - IRF	35,865	3,525	32,340	159,800	304	5.00
6.00	50.00	OPERATING ROOM	669,996	669,996	0	159,800	0	6.00
7.00	53.00	ANESTHESIOLOGY	5,343,233	5,343,233	0	167,500	0	7.00
8.00	55.00	RADIOLOGY - THERAPEUTIC	19,299	19,299	0	217,600	0	8.00
9.00	60.00	LABORATORY	140,425	39,702	100,723	208,000	1,007	9.00
10.00	65.00	RESPIRATORY THERAPY	21,800	21,800	0	159,800	0	10.00
11.00	67.00	OCCUPATIONAL THERAPY	0	0	0	159,800	0	11.00
12.00	69.00	ELECTROCARDIOLOGY	897,721	778,346	119,375	159,800	1,194	12.00
13.00	69.01	CARDIAC REHABILITATION	18,572	8,587	9,985	159,800	65	13.00
14.00	70.00	ELECTROENCEPHALOGRAPHY	10,200	0	10,200	159,800	102	14.00
15.00	74.00	RENAL DIALYSIS	61,071	8,571	52,500	159,800	260	15.00
16.00	91.00	EMERGENCY	1,056,867	1,056,867	0	159,800	0	16.00
200.00			14,597,688	14,051,735	545,953		4,310	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	77,365	3,868	0	0	0	1.00
2.00	17.00	SOCIAL SERVICE	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	19,514	976	0	0	0	3.00
4.00	31.00	INTENSIVE CARE UNIT	8,989	449	0	0	0	4.00
5.00	41.00	SUBPROVIDER - IRF	23,355	1,168	0	0	0	5.00
6.00	50.00	OPERATING ROOM	0	0	0	0	0	6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	7.00
8.00	55.00	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	8.00
9.00	60.00	LABORATORY	100,700	5,035	0	0	0	9.00
10.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	10.00
11.00	67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	11.00
12.00	69.00	ELECTROCARDIOLOGY	91,731	4,587	0	0	0	12.00
13.00	69.01	CARDIAC REHABILITATION	4,994	250	0	0	0	13.00
14.00	70.00	ELECTROENCEPHALOGRAPHY	7,836	392	0	0	0	14.00
15.00	74.00	RENAL DIALYSIS	19,975	999	0	0	0	15.00
16.00	91.00	EMERGENCY	0	0	0	0	0	16.00
200.00			354,459	17,724	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	77,365	78,286	534,503	1.00
2.00	17.00	SOCIAL SERVICE	0	0	0	28,896	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	19,514	27,384	5,644,080	3.00
4.00	31.00	INTENSIVE CARE UNIT	0	8,989	9,292	9,292	4.00
5.00	41.00	SUBPROVIDER - IRF	0	23,355	8,985	12,510	5.00
6.00	50.00	OPERATING ROOM	0	0	0	669,996	6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	5,343,233	7.00
8.00	55.00	RADIOLOGY - THERAPEUTIC	0	0	0	19,299	8.00
9.00	60.00	LABORATORY	0	100,700	23	39,725	9.00
10.00	65.00	RESPIRATORY THERAPY	0	0	0	21,800	10.00
11.00	67.00	OCCUPATIONAL THERAPY	0	0	0	0	11.00
12.00	69.00	ELECTROCARDIOLOGY	0	91,731	27,644	805,990	12.00
13.00	69.01	CARDIAC REHABILITATION	0	4,994	4,991	13,578	13.00
14.00	70.00	ELECTROENCEPHALOGRAPHY	0	7,836	2,364	2,364	14.00
15.00	74.00	RENAL DIALYSIS	0	19,975	32,525	41,096	15.00
16.00	91.00	EMERGENCY	0	0	0	1,056,867	16.00
200.00			0	354,459	191,494	14,243,229	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0046

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

Worksheet B
Part I
Date/Time Prepared:
5/28/2019 11:42 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	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	9,864,677	9,864,677			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	5,287,417		5,287,417		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	16,814,530	283,233	340	17,098,103	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	26,245,219	0	206,258	1,277,022	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	5,149,874	1,786,221	3,231,471	285,013	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	610,492	123,683	403	35,447	8.00
9.00 00900	HOUSEKEEPING	1,847,149	288,410	6,269	462,993	9.00
10.00 01000	DIETARY	609,144	111,350	3,640	111,003	10.00
11.00 01100	CAFETERIA	860,543	290,854	0	295,679	11.00
13.00 01300	NURSING ADMINISTRATION	917,343	55,180	158,488	263,730	13.00
14.00 01400	CENTRAL SERVICE & SUPPLY	369,169	0	7,583	38,694	14.00
15.00 01500	PHARMACY	2,602,262	98,260	8,976	651,314	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	844,767	117,924	161	225,164	16.00
17.00 01700	SOCIAL SERVICE	1,396,861	98,318	0	367,623	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	10,277,889	1,630,456	7,404	4,733,119	30.00
31.00 03100	INTENSIVE CARE UNIT	2,067,152	509,423	50,904	616,045	31.00
41.00 04100	SUBPROVIDER - IRF	727,409	262,609	0	232,877	41.00
43.00 04300	NURSERY	460,852	31,154	0	124,345	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	4,964,459	914,070	279,345	1,022,375	50.00
51.00 05100	RECOVERY ROOM	398,918	0	5,376	126,809	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,766,074	280,993	34,786	577,434	52.00
53.00 05300	ANESTHESIOLOGY	255,731	7,447	11,938	9,091	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,591,619	651,316	193,767	464,643	54.00
55.00 05500	RADIOLOGY - THERAPEUTIC	739,008	0	10,567	230,005	55.00
56.00 05600	RADIOISOTOPE	501,658	0	3,192	72,061	56.00
57.00 05700	CT SCAN	590,271	112,193	12,175	166,317	57.00
58.00 05800	MRI	205,499	63,151	2,524	61,931	58.00
59.00 05900	CARDIAC CATHETERIZATION	912,700	191,546	43,473	283,836	59.00
60.00 06000	LABORATORY	5,449,081	258,449	52,058	720,893	60.00
64.00 06400	INTRAVENOUS THERAPY	260,954	39,386	0	81,177	64.00
65.00 06500	RESPIRATORY THERAPY	1,375,051	42,818	44,472	406,372	65.00
66.00 06600	PHYSICAL THERAPY	1,184,942	108,790	2,317	374,595	66.00
66.01 06601	CLINICAL NUTRITION	185,870	0	0	59,339	66.01
67.00 06700	OCCUPATIONAL THERAPY	449,402	100,151	518	142,559	67.00
68.00 06800	SPEECH PATHOLOGY	273,678	19,809	434	85,833	68.00
69.00 06900	ELECTROCARDIOLOGY	655,059	509,627	31,822	148,592	69.00
69.01 06901	CARDIAC REHABILITATION	169,540	0	6,878	57,697	69.01
70.00 07000	ELECTROENCEPHALOGRAPHY	69,272	0	1,392	18,516	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	8,616,347	0	0	0	71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	5,656,423	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	17,342,262	0	2,685	401,295	73.00
74.00 07400	RENAL DIALYSIS	437,718	0	1,393	19,539	74.00
76.00 03950	ACUTE DIALYSIS	146,788	30,834	62,425	41,826	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	4,432,693	62,889	39,188	693,524	90.00
91.00 09100	EMERGENCY	2,799,348	453,312	29,210	850,107	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)					92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	148,383,114	9,533,856	4,553,832	16,836,434	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	72,644	41,393	435	20,244	190.00
192.00 19200	PHYSICIANS PRIVATE OFFICES	145,534	0	180,518	140,146	192.00
194.00 07950	NON-REIMBURSABLE	1,235,256	289,428	552,632	101,279	194.00
194.01 07951	CONTRACT PHARMACY	745,517	0	0	0	194.01
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	150,582,065	9,864,677	5,287,417	17,098,103	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0046

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

Worksheet B
Part I
Date/Time Prepared:
5/28/2019 11:42 am

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	27,728,499				5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0			6.00
7.00	00700	OPERATION OF PLANT	2,359,189	0	12,811,768		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	173,798	0	203,279	1,147,102	8.00
9.00	00900	HOUSEKEEPING	587,919	0	474,014	5,747	3,672,501
10.00	01000	DIETARY	188,494	0	183,008	2,196	55,388
11.00	01100	CAFETERIA	326,611	0	478,030	5,850	144,676
13.00	01300	NURSING ADMINISTRATION	314,799	0	90,691	0	27,448
14.00	01400	CENTRAL SERVICE & SUPPLY	93,768	0	0	0	0
15.00	01500	PHARMACY	758,549	0	161,495	0	48,877
16.00	01600	MEDICAL RECORDS & LIBRARY	268,140	0	193,813	0	58,658
17.00	01700	SOCIAL SERVICE	420,442	0	161,590	0	48,906
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,757,716	0	2,679,723	539,756	811,023
31.00	03100	INTENSIVE CARE UNIT	732,076	0	837,258	111,147	253,397
41.00	04100	SUBPROVIDER - IRF	276,012	0	431,609	57,470	130,627
43.00	04300	NURSERY	139,113	0	51,202	17,241	15,496
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,620,611	0	1,502,312	95,746	454,677
51.00	05100	RECOVERY ROOM	119,872	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	600,212	0	461,823	0	139,771
53.00	05300	ANESTHESIOLOGY	64,147	0	12,239	0	3,704
54.00	05400	RADIOLOGY-DIAGNOSTIC	654,845	0	1,070,464	104,710	323,977
55.00	05500	RADIOLOGY - THERAPEUTIC	221,095	0	0	0	0
56.00	05600	RADIOISOTOPE	130,211	0	0	0	0
57.00	05700	CT SCAN	198,835	0	184,395	0	55,793
58.00	05800	MRI	75,183	0	103,791	22,989	31,412
59.00	05900	CARDIAC CATHETERIZATION	323,108	0	314,814	11,494	95,279
60.00	06000	LABORATORY	1,462,670	0	424,772	0	128,558
64.00	06400	INTRAVENOUS THERAPY	86,110	0	64,732	0	19,591
65.00	06500	RESPIRATORY THERAPY	421,776	0	70,373	0	21,299
66.00	06600	PHYSICAL THERAPY	377,071	0	178,801	0	54,114
66.01	06601	CLINICAL NUTRITION	55,345	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	156,329	0	164,602	0	49,817
68.00	06800	SPEECH PATHOLOGY	85,712	0	32,557	0	9,853
69.00	06900	ELECTROCARDIOLOGY	303,594	0	837,592	5,747	253,498
69.01	06901	CARDIAC REHABILITATION	52,841	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	20,128	0	0	2,873	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1,944,744	0	0	0	0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	1,276,677	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	4,005,354	0	0	37,126	0
74.00	07400	RENAL DIALYSIS	103,519	0	0	2,529	0
76.00	03950	ACUTE DIALYSIS	63,620	0	50,676	0	15,337
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,180,047	0	103,360	0	31,282
91.00	09100	EMERGENCY	932,604	0	745,036	116,435	225,486
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,932,886	0	12,268,051	1,139,056	3,507,944
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	30,406	0	68,030	0	20,590
192.00	19200	PHYSICIANS PRIVATE OFFICES	105,223	0	0	0	0
194.00	07950	NON-REIMBURSABLE	491,718	0	475,687	8,046	143,967
194.01	07951	CONTRACT PHARMACY	168,266	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	27,728,499	0	12,811,768	1,147,102	3,672,501

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 14-0046		Period: From 01/01/2018 To 12/31/2018		Worksheet B Part I Date/Time Prepared: 5/28/2019 11:42 am	
Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,264,223					10.00
11.00	01100	CAFETERIA	0	2,402,243				11.00
13.00	01300	NURSING ADMINISTRATION	0	34,220	1,861,899			13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	6,844	5,400	521,458		14.00
15.00	01500	PHARMACY	0	85,550	66,981	0	4,482,264	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	54,752	44,013	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	61,596	48,115	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,036,125	643,335	507,826	0	483	30.00
31.00	03100	INTENSIVE CARE UNIT	64,538	102,660	80,017	0	44	31.00
41.00	04100	SUBPROVIDER - IRF	50,841	37,642	29,565	0	0	41.00
43.00	04300	NURSERY	0	20,532	15,940	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	70,076	181,366	142,304	0	0	50.00
51.00	05100	RECOVERY ROOM	0	17,110	13,373	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	92,394	74,023	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	3,422	1,788	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	85,550	66,660	0	247	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	37,642	30,591	0	0	55.00
56.00	05600	RADIOISOTOPE	0	10,266	7,544	0	0	56.00
57.00	05700	CT SCAN	0	30,798	23,114	0	23	57.00
58.00	05800	MRI	0	10,266	7,502	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	54,752	42,267	0	129	59.00
60.00	06000	LABORATORY	0	150,568	119,139	0	6	60.00
64.00	06400	INTRAVENOUS THERAPY	0	13,688	11,112	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	82,128	63,872	0	170	65.00
66.00	06600	PHYSICAL THERAPY	0	58,174	47,028	0	5	66.00
66.01	06601	CLINICAL NUTRITION	0	13,688	9,975	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	20,532	16,440	0	239	67.00
68.00	06800	SPEECH PATHOLOGY	0	13,688	9,905	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	30,798	23,858	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0	10,266	7,950	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,422	2,734	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	521,449	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	78,706	62,748	0	4,480,777	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ACUTE DIALYSIS	0	6,844	4,691	0	20	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	167,678	132,410	0	0	90.00
91.00	09100	EMERGENCY	42,643	147,146	116,164	0	121	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,264,223	2,368,023	1,835,049	521,449	4,482,264	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	6,844	5,020	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	10,266	9,162	0	0	192.00
194.00	07950	NON-REIMBURSABLE	0	17,110	12,668	9	0	194.00
194.01	07951	CONTRACT PHARMACY	0	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)	1,264,223	2,402,243	1,861,899	521,458	4,482,264	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0046

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,807,392				16.00
17.00	01700	SOCIAL SERVICE	0	2,603,451			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	112,536	2,238,967	28,976,358	0	28,976,358
31.00	03100	INTENSIVE CARE UNIT	19,512	234,311	5,678,484	0	5,678,484
41.00	04100	SUBPROVIDER - I R F	5,796	130,173	2,372,630	0	2,372,630
43.00	04300	NURSERY	7,220	0	883,095	0	883,095
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	210,405	0	11,457,746	0	11,457,746
51.00	05100	RECOVERY ROOM	30,670	0	712,128	0	712,128
52.00	05200	DELIVERY ROOM & LABOR ROOM	42,433	0	4,069,943	0	4,069,943
53.00	05300	ANESTHESIOLOGY	44,465	0	413,972	0	413,972
54.00	05400	RADIOLOGY-DIAGNOSTIC	65,967	0	5,273,765	0	5,273,765
55.00	05500	RADIOLOGY - THERAPEUTIC	15,382	0	1,284,290	0	1,284,290
56.00	05600	RADIOISOTOPE	28,579	0	753,511	0	753,511
57.00	05700	CT SCAN	164,915	0	1,538,829	0	1,538,829
58.00	05800	MRI	29,541	0	613,789	0	613,789
59.00	05900	CARDIAC CATHETERIZATION	106,397	0	2,379,795	0	2,379,795
60.00	06000	LABORATORY	250,385	0	9,016,579	0	9,016,579
64.00	06400	INTRAVENOUS THERAPY	4,239	0	580,989	0	580,989
65.00	06500	RESPIRATORY THERAPY	53,731	0	2,582,062	0	2,582,062
66.00	06600	PHYSICAL THERAPY	26,580	0	2,412,417	0	2,412,417
66.01	06601	CLINICAL NUTRITION	218	0	324,435	0	324,435
67.00	06700	OCCUPATIONAL THERAPY	10,531	0	1,111,120	0	1,111,120
68.00	06800	SPEECH PATHOLOGY	3,490	0	534,959	0	534,959
69.00	06900	ELECTROCARDIOLOGY	61,893	0	2,862,080	0	2,862,080
69.01	06901	CARDIAC REHABILITATION	2,347	0	307,519	0	307,519
70.00	07000	ELECTROENCEPHALOGRAPHY	829	0	119,166	0	119,166
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	32,039	0	11,114,579	0	11,114,579
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	65,234	0	6,998,334	0	6,998,334
73.00	07300	DRUGS CHARGED TO PATIENTS	244,588	0	26,655,541	0	26,655,541
74.00	07400	RENAL DIALYSIS	4,644	0	569,342	0	569,342
76.00	03950	ACUTE DIALYSIS	14,526	0	437,587	0	437,587
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	44,398	0	6,887,469	0	6,887,469
91.00	09100	EMERGENCY	101,660	0	6,559,272	0	6,559,272
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)				0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,805,150	2,603,451	145,481,785	0	145,481,785
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	265,606	0	265,606
192.00	19200	PHYSICIANS PRIVATE OFFICES	2,242	0	593,091	0	593,091
194.00	07950	NON-REIMBURSABLE	0	0	3,327,800	0	3,327,800
194.01	07951	CONTRACT PHARMACY	0	0	913,783	0	913,783
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)	1,807,392	2,603,451	150,582,065	0	150,582,065

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0046

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT		
		BLDG & FIXT	MVBLE EQUIP				
		0	1.00				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	283,233	340	283,573	283,573	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	1,180,019	0	206,258	1,386,277	21,179	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	39,288	1,786,221	3,231,471	5,056,980	4,727	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	123,683	403	124,086	588	8.00
9.00 00900	HOUSEKEEPING	48,542	288,410	6,269	343,221	7,679	9.00
10.00 01000	DIETARY	0	111,350	3,640	114,990	1,841	10.00
11.00 01100	CAFETERIA	0	290,854	0	290,854	4,904	11.00
13.00 01300	NURSING ADMINISTRATION	0	55,180	158,488	213,668	4,374	13.00
14.00 01400	CENTRAL SERVICE & SUPPLY	37,162	0	7,583	44,745	642	14.00
15.00 01500	PHARMACY	205,419	98,260	8,976	312,655	10,802	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	117,924	161	118,085	3,734	16.00
17.00 01700	SOCIAL SERVICE	0	98,318	0	98,318	6,097	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	55,864	1,630,456	7,404	1,693,724	78,501	30.00
31.00 03100	INTENSIVE CARE UNIT	12,480	509,423	50,904	572,807	10,217	31.00
41.00 04100	SUBPROVIDER - IRF	0	262,609	0	262,609	3,862	41.00
43.00 04300	NURSERY	0	31,154	0	31,154	2,062	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	416,222	914,070	279,345	1,609,637	16,956	50.00
51.00 05100	RECOVERY ROOM	0	0	5,376	5,376	2,103	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	280,993	34,786	315,779	9,577	52.00
53.00 05300	ANESTHESIOLOGY	0	7,447	11,938	19,385	151	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	21,862	651,316	193,767	866,945	7,706	54.00
55.00 05500	RADIOLOGY - THERAPEUTIC	0	0	10,567	10,567	3,815	55.00
56.00 05600	RADIOISOTOPE	0	0	3,192	3,192	1,195	56.00
57.00 05700	CT SCAN	0	112,193	12,175	124,368	2,758	57.00
58.00 05800	MRI	0	63,151	2,524	65,675	1,027	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	191,546	43,473	235,019	4,707	59.00
60.00 06000	LABORATORY	0	258,449	52,058	310,507	11,956	60.00
64.00 06400	INTRAVENOUS THERAPY	0	39,386	0	39,386	1,346	64.00
65.00 06500	RESPIRATORY THERAPY	20,528	42,818	44,472	107,818	6,740	65.00
66.00 06600	PHYSICAL THERAPY	328	108,790	2,317	111,435	6,213	66.00
66.01 06601	CLINICAL NUTRITION	0	0	0	0	984	66.01
67.00 06700	OCCUPATIONAL THERAPY	0	100,151	518	100,669	2,364	67.00
68.00 06800	SPEECH PATHOLOGY	0	19,809	434	20,243	1,424	68.00
69.00 06900	ELECTROCARDIOLOGY	0	509,627	31,822	541,449	2,464	69.00
69.01 06901	CARDIAC REHABILITATION	0	0	6,878	6,878	957	69.01
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	1,392	1,392	307	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	2,685	2,685	6,655	73.00
74.00 07400	RENAL DIALYSIS	0	0	1,393	1,393	324	74.00
76.00 03950	ACUTE DIALYSIS	0	30,834	62,425	93,259	694	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	583,226	62,889	39,188	685,303	11,502	90.00
91.00 09100	EMERGENCY	120	453,312	29,210	482,642	14,099	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)				0		92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	2,621,060	9,533,856	4,553,832	16,708,748	279,233	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	0	41,393	435	41,828	336	190.00
192.00 19200	PHYSICIANS PRIVATE OFFICES	0	0	180,518	180,518	2,324	192.00
194.00 07950	NON-REIMBURSABLE	1,292,080	289,428	552,632	2,134,140	1,680	194.00
194.01 07951	CONTRACT 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)	3,913,140	9,864,677	5,287,417	19,065,234	283,573	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part II Date/Time Prepared: 5/28/2019 11:42 am		
Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING
			5.00	6.00	7.00	8.00	9.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,407,456				5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0			6.00
7.00	00700	OPERATION OF PLANT	119,745	0	5,181,452		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,821	0	82,212	215,707	8.00
9.00	00900	HOUSEKEEPING	29,841	0	191,705	1,081	573,527
10.00	01000	DIETARY	9,567	0	74,014	413	8,650
11.00	01100	CAFETERIA	16,578	0	193,329	1,100	22,594
13.00	01300	NURSING ADMINISTRATION	15,978	0	36,678	0	4,286
14.00	01400	CENTRAL SERVICE & SUPPLY	4,759	0	0	0	0
15.00	01500	PHARMACY	38,501	0	65,313	0	7,633
16.00	01600	MEDICAL RECORDS & LIBRARY	13,610	0	78,384	0	9,160
17.00	01700	SOCIAL SERVICE	21,340	0	65,352	0	7,637
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	190,729	0	1,083,756	101,499	126,655
31.00	03100	INTENSIVE CARE UNIT	37,158	0	338,611	20,901	39,573
41.00	04100	SUBPROVIDER - IRF	14,009	0	174,555	10,807	20,400
43.00	04300	NURSERY	7,061	0	20,708	3,242	2,420
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	82,257	0	607,579	18,005	71,006
51.00	05100	RECOVERY ROOM	6,084	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	30,465	0	186,775	0	21,828
53.00	05300	ANESTHESIOLOGY	3,256	0	4,950	0	578
54.00	05400	RADIOLOGY-DIAGNOSTIC	33,238	0	432,927	19,690	50,595
55.00	05500	RADIOLOGY - THERAPEUTIC	11,222	0	0	0	0
56.00	05600	RADIOISOTOPE	6,609	0	0	0	0
57.00	05700	CT SCAN	10,092	0	74,575	0	8,713
58.00	05800	MRI	3,816	0	41,976	4,323	4,906
59.00	05900	CARDIAC CATHETERIZATION	16,400	0	127,320	2,161	14,880
60.00	06000	LABORATORY	74,240	0	171,790	0	20,077
64.00	06400	INTRAVENOUS THERAPY	4,371	0	26,179	0	3,060
65.00	06500	RESPIRATORY THERAPY	21,408	0	28,461	0	3,326
66.00	06600	PHYSICAL THERAPY	19,139	0	72,312	0	8,451
66.01	06601	CLINICAL NUTRITION	2,809	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	7,935	0	66,570	0	7,780
68.00	06800	SPEECH PATHOLOGY	4,350	0	13,167	0	1,539
69.00	06900	ELECTROCARDIOLOGY	15,409	0	338,747	1,081	39,588
69.01	06901	CARDIAC REHABILITATION	2,682	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	1,022	0	0	540	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	98,709	0	0	0	0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	64,800	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	203,349	0	0	6,981	0
74.00	07400	RENAL DIALYSIS	5,254	0	0	475	0
76.00	03950	ACUTE DIALYSIS	3,229	0	20,495	0	2,395
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	59,895	0	41,802	0	4,885
91.00	09100	EMERGENCY	47,336	0	301,314	21,895	35,214
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,367,073	0	4,961,556	214,194	547,829
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	1,543	0	27,514	0	3,215
192.00	19200	PHYSICIANS PRIVATE OFFICES	5,341	0	0	0	0
194.00	07950	NON-REIMBURSABLE	24,958	0	192,382	1,513	22,483
194.01	07951	CONTRACT PHARMACY	8,541	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	1,407,456	0	5,181,452	215,707	573,527

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0046		Period: From 01/01/2018 To 12/31/2018		Worksheet B Part II Date/Time Prepared: 5/28/2019 11:42 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	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICE & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	241,717					16.00
17.00	01700	SOCIAL SERVICE	0	219,618				17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,060	188,871	3,869,351	0	3,869,351	30.00
31.00	03100	INTENSIVE CARE UNIT	2,611	19,766	1,087,107	0	1,087,107	31.00
41.00	04100	SUBPROVIDER - I R F	776	10,981	519,204	0	519,204	41.00
43.00	04300	NURSERY	966	0	74,556	0	74,556	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	28,157	0	2,506,767	0	2,506,767	50.00
51.00	05100	RECOVERY ROOM	4,104	0	23,466	0	23,466	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,678	0	601,694	0	601,694	52.00
53.00	05300	ANESTHESIOLOGY	5,950	0	35,295	0	35,295	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,828	0	1,448,922	0	1,448,922	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	2,059	0	40,600	0	40,600	55.00
56.00	05600	RADIOISOTOPE	3,825	0	18,228	0	18,228	56.00
57.00	05700	CT SCAN	22,069	0	252,871	0	252,871	57.00
58.00	05800	MRI	3,953	0	129,076	0	129,076	58.00
59.00	05900	CARDIAC CATHETERIZATION	14,238	0	433,217	0	433,217	59.00
60.00	06000	LABORATORY	33,354	0	673,182	0	673,182	60.00
64.00	06400	INTRAVENOUS THERAPY	567	0	79,611	0	79,611	64.00
65.00	06500	RESPIRATORY THERAPY	7,190	0	202,751	0	202,751	65.00
66.00	06600	PHYSICAL THERAPY	3,557	0	241,062	0	241,062	66.00
66.01	06601	CLINICAL NUTRITION	29	0	8,352	0	8,352	66.01
67.00	06700	OCCUPATIONAL THERAPY	1,409	0	193,771	0	193,771	67.00
68.00	06800	SPEECH PATHOLOGY	467	0	45,709	0	45,709	68.00
69.00	06900	ELECTROCARDIOLOGY	8,283	0	957,428	0	957,428	69.00
69.01	06901	CARDIAC REHABILITATION	314	0	14,299	0	14,299	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	111	0	4,541	0	4,541	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	4,288	0	155,469	0	155,469	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	8,730	0	73,530	0	73,530	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,732	0	743,032	0	743,032	73.00
74.00	07400	RENAL DIALYSIS	622	0	8,068	0	8,068	74.00
76.00	03950	ACUTE DIALYSIS	1,944	0	124,238	0	124,238	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	5,942	0	866,371	0	866,371	90.00
91.00	09100	EMERGENCY	13,604	0	973,235	0	973,235	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)				0		92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	241,417	219,618	16,405,003	0	16,405,003	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	76,706	0	76,706	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	300	0	192,135	0	192,135	192.00
194.00	07950	NON-REIMBURSABLE	0	0	2,382,849	0	2,382,849	194.00
194.01	07951	CONTRACT PHARMACY	0	0	8,541	0	8,541	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)	241,717	219,618	19,065,234	0	19,065,234	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0046

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

Worksheet B-1

Date/Time Prepared:
5/28/2019 11:42 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQ FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT	339,129					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		12,777,883				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	9,737	822	53,442,935			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	498,455	3,991,543	-27,728,499	122,853,566	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	61,407	7,809,352	890,854	0	10,452,579	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	4,252	974	110,794	0	770,025	8.00
9.00 00900	HOUSEKEEPING	9,915	15,151	1,447,161	0	2,604,821	9.00
10.00 01000	DIETARY	3,828	8,796	346,957	0	835,137	10.00
11.00 01100	CAFETERIA	9,999	0	924,194	0	1,447,076	11.00
13.00 01300	NURSING ADMINISTRATION	1,897	383,013	824,332	0	1,394,741	13.00
14.00 01400	CENTRAL SERVICE & SUPPLY	0	18,325	120,945	0	415,446	14.00
15.00 01500	PHARMACY	3,378	21,692	2,035,789	0	3,360,812	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	4,054	388	703,786	0	1,188,016	16.00
17.00 01700	SOCIAL SERVICE	3,380	0	1,149,066	0	1,862,802	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	56,052	17,894	14,794,155	0	16,648,868	30.00
31.00 03100	INTENSIVE CARE UNIT	17,513	123,017	1,925,551	0	3,243,524	31.00
41.00 04100	SUBPROVIDER - IRF	9,028	0	727,895	0	1,222,895	41.00
43.00 04300	NURSERY	1,071	0	388,661	0	616,351	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	31,424	675,082	3,195,600	0	7,180,249	50.00
51.00 05100	RECOVERY ROOM	0	12,991	396,362	0	531,103	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	9,660	84,067	1,804,865	0	2,659,287	52.00
53.00 05300	ANESTHESIOLOGY	256	28,851	28,415	0	284,207	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	22,391	468,270	1,452,317	0	2,901,345	54.00
55.00 05500	RADIOLOGY - THERAPEUTIC	0	25,537	718,919	0	979,580	55.00
56.00 05600	RADIOISOTOPE	0	7,714	225,237	0	576,911	56.00
57.00 05700	CT SCAN	3,857	29,424	519,850	0	880,956	57.00
58.00 05800	MRI	2,171	6,099	193,576	0	333,105	58.00
59.00 05900	CARDIAC CATHETERIZATION	6,585	105,060	887,176	0	1,431,555	59.00
60.00 06000	LABORATORY	8,885	125,806	2,253,269	0	6,480,481	60.00
64.00 06400	INTRAVENOUS THERAPY	1,354	0	253,731	0	381,517	64.00
65.00 06500	RESPIRATORY THERAPY	1,472	107,474	1,270,181	0	1,868,713	65.00
66.00 06600	PHYSICAL THERAPY	3,740	5,599	1,170,858	0	1,670,644	66.00
66.01 06601	CLINICAL NUTRITION	0	0	185,475	0	245,209	66.01
67.00 06700	OCCUPATIONAL THERAPY	3,443	1,253	445,593	0	692,630	67.00
68.00 06800	SPEECH PATHOLOGY	681	1,048	268,286	0	379,754	68.00
69.00 06900	ELECTROCARDIOLOGY	17,520	76,904	464,448	0	1,345,100	69.00
69.01 06901	CARDIAC REHABILITATION	0	16,623	180,342	0	234,115	69.01
70.00 07000	ELECTROENCEPHALOGRAPHY	0	3,365	57,874	0	89,180	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	8,616,347	71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	5,656,423	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	6,488	1,254,312	0	17,746,242	73.00
74.00 07400	RENAL DIALYSIS	0	3,366	61,071	0	458,650	74.00
76.00 03950	ACUTE DIALYSIS	1,060	150,860	130,734	0	281,873	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	2,162	94,704	2,167,724	0	5,228,294	90.00
91.00 09100	EMERGENCY	15,584	70,591	2,657,148	0	4,131,977	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)						92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	327,756	11,005,055	52,625,046	-27,728,499	119,328,540	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	1,423	1,052	63,275	0	134,716	190.00
192.00 19200	PHYSICIANS PRIVATE OFFICES	0	436,251	438,050	0	466,198	192.00
194.00 07950	NON-REIMBURSABLE	9,950	1,335,525	316,564	0	2,178,595	194.00
194.01 07951	CONTRACT PHARMACY	0	0	0	0	745,517	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)	9,864,677	5,287,417	17,098,103		27,728,499	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	29.088273	0.413794	0.319932		0.225704	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			283,573		1,407,456	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.005306		0.011456	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0046

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

Worksheet B-1
Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQ FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00	4.00				
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: 14-0046

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

Worksheet B-1

Date/Time Prepared:
5/28/2019 11:42 am

Cost Center Description		MAINTENANCE & REPAIRS (MAINTENANCE & REPAIRS)	OPERATION OF PLANT (SQ FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQ FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	0				6.00
7.00	00700	OPERATION OF PLANT	0	267,985			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,252	921,833		8.00
9.00	00900	HOUSEKEEPING	0	9,915	4,618	253,817	9.00
10.00	01000	DIETARY	0	3,828	1,765	3,828	127,837
11.00	01100	CAFETERIA	0	9,999	4,701	9,999	0
13.00	01300	NURSING ADMINISTRATION	0	1,897	0	1,897	0
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	0
15.00	01500	PHARMACY	0	3,378	0	3,378	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,054	0	4,054	0
17.00	01700	SOCIAL SERVICE	0	3,380	0	3,380	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	56,052	433,760	56,052	104,772
31.00	03100	INTENSIVE CARE UNIT	0	17,513	89,320	17,513	6,526
41.00	04100	SUBPROVIDER - I RF	0	9,028	46,184	9,028	5,141
43.00	04300	NURSERY	0	1,071	13,855	1,071	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	31,424	76,943	31,424	7,086
51.00	05100	RECOVERY ROOM	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	9,660	0	9,660	0
53.00	05300	ANESTHESIOLOGY	0	256	0	256	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,391	84,147	22,391	0
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	3,857	0	3,856	0
58.00	05800	MRI	0	2,171	18,474	2,171	0
59.00	05900	CARDIAC CATHETERIZATION	0	6,585	9,237	6,585	0
60.00	06000	LABORATORY	0	8,885	0	8,885	0
64.00	06400	INTRAVENOUS THERAPY	0	1,354	0	1,354	0
65.00	06500	RESPIRATORY THERAPY	0	1,472	0	1,472	0
66.00	06600	PHYSICAL THERAPY	0	3,740	0	3,740	0
66.01	06601	CLINICAL NUTRITION	0	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	0	3,443	0	3,443	0
68.00	06800	SPEECH PATHOLOGY	0	681	0	681	0
69.00	06900	ELECTROCARDIOLOGY	0	17,520	4,618	17,520	0
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	2,309	0	0
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	29,835	0	0
74.00	07400	RENAL DIALYSIS	0	0	2,032	0	0
76.00	03950	ACUTE DIALYSIS	0	1,060	0	1,060	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	2,162	0	2,162	0
91.00	09100	EMERGENCY	0	15,584	93,569	15,584	4,312
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	256,612	915,367	242,444	127,837
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	1,423	0	1,423	0
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0
194.00	07950	NON-REIMBURSABLE	0	9,950	6,466	9,950	0
194.01	07951	CONTRACT 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	12,811,768	1,147,102	3,672,501	1,264,223
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	47.807780	1.244371	14.469090	9.889336
204.00		Cost to be allocated (per Wkst. B, Part II)	0	5,181,452	215,707	573,527	209,475
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	19.334858	0.233998	2.259608	1.638610
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0046

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

Worksheet B-1
Date/Time Prepared:
5/28/2019 11:42 am

Cost Center Description		CAFETERIA (FTES SERVED)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (ADMINISTRATIVE CHARGES)	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	702					11.00
13.00	01300	10	1,431,962				13.00
14.00	01400	2	4,153	8,900,639			14.00
15.00	01500	25	51,514	0	16,066,273		15.00
16.00	01600	16	33,850	0	0	577,235,967	16.00
17.00	01700	18	37,005	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	188	390,561	0	1,731	35,942,421	30.00
31.00	03100	30	61,540	0	156	6,231,966	31.00
41.00	04100	11	22,738	0	0	1,851,055	41.00
43.00	04300	6	12,259	0	0	2,306,127	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	53	109,444	0	0	67,200,672	50.00
51.00	05100	5	10,285	0	0	9,795,516	51.00
52.00	05200	27	56,930	0	0	13,552,385	52.00
53.00	05300	1	1,375	0	0	14,201,409	53.00
54.00	05400	25	51,267	0	887	21,069,118	54.00
55.00	05500	11	23,527	0	0	4,912,935	55.00
56.00	05600	3	5,802	0	0	9,127,839	56.00
57.00	05700	9	17,777	0	81	52,671,522	57.00
58.00	05800	3	5,770	0	0	9,435,128	58.00
59.00	05900	16	32,507	0	463	33,981,892	59.00
60.00	06000	44	91,628	0	21	79,948,278	60.00
64.00	06400	4	8,546	0	0	1,353,791	64.00
65.00	06500	24	49,123	0	610	17,160,995	65.00
66.00	06600	17	36,169	0	17	8,489,399	66.00
66.01	06601	4	7,672	0	0	69,480	66.01
67.00	06700	6	12,644	0	856	3,363,507	67.00
68.00	06800	4	7,618	0	0	1,114,614	68.00
69.00	06900	4	18,349	0	0	19,767,737	69.00
69.01	06901	3	6,114	0	0	749,655	69.01
70.00	07000	1	2,103	0	0	264,780	70.00
71.00	07100	0	0	8,900,491	0	10,232,912	71.00
72.00	07200	0	0	0	0	20,834,890	72.00
73.00	07300	23	48,259	0	16,060,947	78,118,216	73.00
74.00	07400	0	0	0	0	1,483,360	74.00
76.00	03950	2	3,608	0	70	4,639,304	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	49	101,835	0	0	14,180,206	90.00
91.00	09100	43	89,340	0	434	32,468,754	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		692	1,411,312	8,900,491	16,066,273	576,519,863	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	2	3,861	0	0	0	190.00
192.00	19200	3	7,046	0	0	716,104	192.00
194.00	07950	5	9,743	148	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00							201.00
202.00		2,402,243	1,861,899	521,458	4,482,264	1,807,392	202.00
203.00		3,421.998575	1.300243	0.058587	0.278986	0.003131	203.00
204.00		529,359	282,525	52,473	463,920	241,717	204.00
205.00		754.072650	0.197299	0.005895	0.028875	0.000419	205.00
206.00							206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0046

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

Worksheet B-1

Date/Time Prepared:
5/28/2019 11:42 am

Cost Center Description		CAFETERIA (FTES SERVED)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (ADMINISTRATING CHARGES)	
		11.00	13.00	14.00	15.00	16.00	
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0046

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

Worksheet B-1

Date/Time Prepared:
5/28/2019 11:42 am

Cost Center Description		SOCIAL SERVICE	
		(TIME SPENT)	
		17.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL 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
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
41.00	04100	SUBPROVIDER - IRF	41.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
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	03950	ACUTE DIALYSIS	76.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	92.00
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	192.00
194.00	07950	NON-REIMBURSABLE	194.00
194.01	07951	CONTRACT 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
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0046

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

Worksheet C
Part I
Date/Time Prepared:
5/28/2019 11:42 am

		Title XVIII		Hospital		PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		28,976,358	27,384	29,003,742	30.00
31.00	03100 INTENSIVE CARE UNIT		5,678,484	9,292	5,687,776	31.00
41.00	04100 SUBPROVIDER - I RF		2,372,630	8,985	2,381,615	41.00
43.00	04300 NURSERY		883,095	0	883,095	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		11,457,746	0	11,457,746	50.00
51.00	05100 RECOVERY ROOM		712,128	0	712,128	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		4,069,943	0	4,069,943	52.00
53.00	05300 ANESTHESIOLOGY		413,972	0	413,972	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		5,273,765	0	5,273,765	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC		1,284,290	0	1,284,290	55.00
56.00	05600 RADIOISOTOPE		753,511	0	753,511	56.00
57.00	05700 CT SCAN		1,538,829	0	1,538,829	57.00
58.00	05800 MRI		613,789	0	613,789	58.00
59.00	05900 CARDIAC CATHETERIZATION		2,379,795	0	2,379,795	59.00
60.00	06000 LABORATORY		9,016,579	23	9,016,602	60.00
64.00	06400 INTRAVENOUS THERAPY		580,989	0	580,989	64.00
65.00	06500 RESPIRATORY THERAPY	0	2,582,062	0	2,582,062	65.00
66.00	06600 PHYSICAL THERAPY	0	2,412,417	0	2,412,417	66.00
66.01	06601 CLINICAL NUTRITION	0	324,435	0	324,435	66.01
67.00	06700 OCCUPATIONAL THERAPY	0	1,111,120	0	1,111,120	67.00
68.00	06800 SPEECH PATHOLOGY	0	534,959	0	534,959	68.00
69.00	06900 ELECTROCARDIOLOGY		2,862,080	27,644	2,889,724	69.00
69.01	06901 CARDIAC REHABILITATION		307,519	4,991	312,510	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY		119,166	2,364	121,530	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT		11,114,579	0	11,114,579	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS		6,998,334	0	6,998,334	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		26,655,541	0	26,655,541	73.00
74.00	07400 RENAL DIALYSIS		569,342	32,525	601,867	74.00
76.00	03950 ACUTE DIALYSIS		437,587	0	437,587	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		6,887,469	0	6,887,469	90.00
91.00	09100 EMERGENCY		6,559,272	0	6,559,272	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)		2,137,122		2,137,122	92.00
200.00	Subtotal (see instructions)	0	147,618,907	113,208	147,732,115	200.00
201.00	Less Observation Beds		2,137,122		2,137,122	201.00
202.00	Total (see instructions)	0	145,481,785	113,208	145,594,993	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/28/2019 11:42 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	35,942,422		35,942,422	30.00
31.00	03100	INTENSIVE CARE UNIT	6,231,966		6,231,966	31.00
41.00	04100	SUBPROVIDER - IRF	1,851,055		1,851,055	41.00
43.00	04300	NURSERY	2,306,127		2,306,127	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	29,160,282	38,040,390	67,200,672	50.00
51.00	05100	RECOVERY ROOM	4,319,363	5,476,153	9,795,516	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,744,704	2,807,681	13,552,385	52.00
53.00	05300	ANESTHESIOLOGY	7,474,685	6,726,724	14,201,409	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,510,383	14,558,735	21,069,118	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	576,660	4,336,275	4,912,935	55.00
56.00	05600	RADIOISOTOPE	2,043,629	7,084,210	9,127,839	56.00
57.00	05700	CT SCAN	14,273,762	38,397,760	52,671,522	57.00
58.00	05800	MRI	1,701,796	7,733,332	9,435,128	58.00
59.00	05900	CARDIAC CATHETERIZATION	18,810,432	15,171,460	33,981,892	59.00
60.00	06000	LABORATORY	34,890,738	45,057,540	79,948,278	60.00
64.00	06400	INTRAVENOUS THERAPY	8,915	1,344,876	1,353,791	64.00
65.00	06500	RESPIRATORY THERAPY	14,640,701	2,520,294	17,160,995	65.00
66.00	06600	PHYSICAL THERAPY	5,628,724	2,860,675	8,489,399	66.00
66.01	06601	CLINICAL NUTRITION	0	69,480	69,480	66.01
67.00	06700	OCCUPATIONAL THERAPY	2,482,760	880,747	3,363,507	67.00
68.00	06800	SPEECH PATHOLOGY	586,601	528,013	1,114,614	68.00
69.00	06900	ELECTROCARDIOLOGY	8,755,658	11,012,079	19,767,737	69.00
69.01	06901	CARDIAC REHABILITATION	123,975	625,680	749,655	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	225,730	39,050	264,780	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	6,823,706	3,409,206	10,232,912	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	12,066,355	8,768,535	20,834,890	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,712,198	48,406,018	78,118,216	73.00
74.00	07400	RENAL DIALYSIS	1,357,780	125,580	1,483,360	74.00
76.00	03950	ACUTE DIALYSIS	1,009,119	3,630,185	4,639,304	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	56,524	14,123,682	14,180,206	90.00
91.00	09100	EMERGENCY	7,849,255	24,619,499	32,468,754	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	238,585	1,863,864	2,102,449	92.00
200.00		Subtotal (see instructions)	268,404,590	310,217,723	578,622,313	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	268,404,590	310,217,723	578,622,313	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/28/2019 11:42 am
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio	
		11.00	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS		30.00
31.00	03100 INTENSIVE CARE UNIT		31.00
41.00	04100 SUBPROVIDER - IRF		41.00
43.00	04300 NURSERY		43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.170500	50.00
51.00	05100 RECOVERY ROOM	0.072699	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.300312	52.00
53.00	05300 ANESTHESIOLOGY	0.029150	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.250308	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.261410	55.00
56.00	05600 RADIOISOTOPE	0.082551	56.00
57.00	05700 CT SCAN	0.029216	57.00
58.00	05800 MRI	0.065054	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.070031	59.00
60.00	06000 LABORATORY	0.112780	60.00
64.00	06400 INTRAVENOUS THERAPY	0.429157	64.00
65.00	06500 RESPIRATORY THERAPY	0.150461	65.00
66.00	06600 PHYSICAL THERAPY	0.284168	66.00
66.01	06601 CLINICAL NUTRITION	4.669473	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.330346	67.00
68.00	06800 SPEECH PATHOLOGY	0.479950	68.00
69.00	06900 ELECTROCARDIOLOGY	0.146184	69.00
69.01	06901 CARDIAC REHABILITATION	0.416872	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.458985	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	1.086160	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.335895	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.341221	73.00
74.00	07400 RENAL DIALYSIS	0.405746	74.00
76.00	03950 ACUTE DIALYSIS	0.094322	76.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0.485710	90.00
91.00	09100 EMERGENCY	0.202018	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	1.016492	92.00
200.00	Subtotal (see instructions)		200.00
201.00	Less Observation Beds		201.00
202.00	Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/28/2019 11:42 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	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		28,976,358	27,384	29,003,742	30.00
31.00	03100 INTENSIVE CARE UNIT		5,678,484	9,292	5,687,776	31.00
41.00	04100 SUBPROVIDER - I RF		2,372,630	8,985	2,381,615	41.00
43.00	04300 NURSERY		883,095	0	883,095	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		11,457,746	0	11,457,746	50.00
51.00	05100 RECOVERY ROOM		712,128	0	712,128	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		4,069,943	0	4,069,943	52.00
53.00	05300 ANESTHESIOLOGY		413,972	0	413,972	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		5,273,765	0	5,273,765	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC		1,284,290	0	1,284,290	55.00
56.00	05600 RADIOISOTOPE		753,511	0	753,511	56.00
57.00	05700 CT SCAN		1,538,829	0	1,538,829	57.00
58.00	05800 MRI		613,789	0	613,789	58.00
59.00	05900 CARDIAC CATHETERIZATION		2,379,795	0	2,379,795	59.00
60.00	06000 LABORATORY		9,016,579	23	9,016,602	60.00
64.00	06400 INTRAVENOUS THERAPY		580,989	0	580,989	64.00
65.00	06500 RESPIRATORY THERAPY	0	2,582,062	0	2,582,062	65.00
66.00	06600 PHYSICAL THERAPY	0	2,412,417	0	2,412,417	66.00
66.01	06601 CLINICAL NUTRITION	0	324,435	0	324,435	66.01
67.00	06700 OCCUPATIONAL THERAPY	0	1,111,120	0	1,111,120	67.00
68.00	06800 SPEECH PATHOLOGY	0	534,959	0	534,959	68.00
69.00	06900 ELECTROCARDIOLOGY		2,862,080	27,644	2,889,724	69.00
69.01	06901 CARDIAC REHABILITATION		307,519	4,991	312,510	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY		119,166	2,364	121,530	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT		11,114,579	0	11,114,579	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS		6,998,334	0	6,998,334	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		26,655,541	0	26,655,541	73.00
74.00	07400 RENAL DIALYSIS		569,342	32,525	601,867	74.00
76.00	03950 ACUTE DIALYSIS		437,587	0	437,587	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		6,887,469	0	6,887,469	90.00
91.00	09100 EMERGENCY		6,559,272	0	6,559,272	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)		2,137,122		2,137,122	92.00
200.00	Subtotal (see instructions)	0	147,618,907	113,208	147,732,115	200.00
201.00	Less Observation Beds		2,137,122		2,137,122	201.00
202.00	Total (see instructions)	0	145,481,785	113,208	145,594,993	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/28/2019 11:42 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	10.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	35,942,422		35,942,422			30.00
31.00 03100 INTENSIVE CARE UNIT	6,231,966		6,231,966			31.00
41.00 04100 SUBPROVIDER - IRF	1,851,055		1,851,055			41.00
43.00 04300 NURSERY	2,306,127		2,306,127			43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	29,160,282	38,040,390	67,200,672	0.170500	0.000000	50.00
51.00 05100 RECOVERY ROOM	4,319,363	5,476,153	9,795,516	0.072699	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	10,744,704	2,807,681	13,552,385	0.300312	0.000000	52.00
53.00 05300 ANESTHESIOLOGY	7,474,685	6,726,724	14,201,409	0.029150	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	6,510,383	14,558,735	21,069,118	0.250308	0.000000	54.00
55.00 05500 RADIOLOGY - THERAPEUTIC	576,660	4,336,275	4,912,935	0.261410	0.000000	55.00
56.00 05600 RADIOISOTOPE	2,043,629	7,084,210	9,127,839	0.082551	0.000000	56.00
57.00 05700 CT SCAN	14,273,762	38,397,760	52,671,522	0.029216	0.000000	57.00
58.00 05800 MRI	1,701,796	7,733,332	9,435,128	0.065054	0.000000	58.00
59.00 05900 CARDIAC CATHETERIZATION	18,810,432	15,171,460	33,981,892	0.070031	0.000000	59.00
60.00 06000 LABORATORY	34,890,738	45,057,540	79,948,278	0.112780	0.000000	60.00
64.00 06400 INTRAVENOUS THERAPY	8,915	1,344,876	1,353,791	0.429157	0.000000	64.00
65.00 06500 RESPIRATORY THERAPY	14,640,701	2,520,294	17,160,995	0.150461	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	5,628,724	2,860,675	8,489,399	0.284168	0.000000	66.00
66.01 06601 CLINICAL NUTRITION	0	69,480	69,480	4.669473	0.000000	66.01
67.00 06700 OCCUPATIONAL THERAPY	2,482,760	880,747	3,363,507	0.330346	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	586,601	528,013	1,114,614	0.479950	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	8,755,658	11,012,079	19,767,737	0.144785	0.000000	69.00
69.01 06901 CARDIAC REHABILITATION	123,975	625,680	749,655	0.410214	0.000000	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	225,730	39,050	264,780	0.450057	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	6,823,706	3,409,206	10,232,912	1.086160	0.000000	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	12,066,355	8,768,535	20,834,890	0.335895	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	29,712,198	48,406,018	78,118,216	0.341221	0.000000	73.00
74.00 07400 RENAL DIALYSIS	1,357,780	125,580	1,483,360	0.383819	0.000000	74.00
76.00 03950 ACUTE DIALYSIS	1,009,119	3,630,185	4,639,304	0.094322	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	56,524	14,123,682	14,180,206	0.485710	0.000000	90.00
91.00 09100 EMERGENCY	7,849,255	24,619,499	32,468,754	0.202018	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT)	238,585	1,863,864	2,102,449	1.016492	0.000000	92.00
200.00 Subtotal (see instructions)	268,404,590	310,217,723	578,622,313			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	268,404,590	310,217,723	578,622,313			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/28/2019 11:42 am
		Title XIX	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio	
		11.00	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS		30.00
31.00	03100 INTENSIVE CARE UNIT		31.00
41.00	04100 SUBPROVIDER - IRF		41.00
43.00	04300 NURSERY		43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.170500	50.00
51.00	05100 RECOVERY ROOM	0.072699	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.300312	52.00
53.00	05300 ANESTHESIOLOGY	0.029150	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.250308	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.261410	55.00
56.00	05600 RADIOISOTOPE	0.082551	56.00
57.00	05700 CT SCAN	0.029216	57.00
58.00	05800 MRI	0.065054	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.070031	59.00
60.00	06000 LABORATORY	0.112780	60.00
64.00	06400 INTRAVENOUS THERAPY	0.429157	64.00
65.00	06500 RESPIRATORY THERAPY	0.150461	65.00
66.00	06600 PHYSICAL THERAPY	0.284168	66.00
66.01	06601 CLINICAL NUTRITION	4.669473	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.330346	67.00
68.00	06800 SPEECH PATHOLOGY	0.479950	68.00
69.00	06900 ELECTROCARDIOLOGY	0.146184	69.00
69.01	06901 CARDIAC REHABILITATION	0.416872	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.458985	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	1.086160	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.335895	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.341221	73.00
74.00	07400 RENAL DIALYSIS	0.405746	74.00
76.00	03950 ACUTE DIALYSIS	0.094322	76.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0.485710	90.00
91.00	09100 EMERGENCY	0.202018	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	1.016492	92.00
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: 14-0046

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

Worksheet C
Part II
Date/Time Prepared:
5/28/2019 11:42 am

Cost Center Description			Title XIX			Hospital	PPS	
			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	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,457,746	2,506,767	8,950,979	0	0	50.00
51.00	05100	RECOVERY ROOM	712,128	23,466	688,662	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,069,943	601,694	3,468,249	0	0	52.00
53.00	05300	ANESTHESIOLOGY	413,972	35,295	378,677	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,273,765	1,448,922	3,824,843	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	1,284,290	40,600	1,243,690	0	0	55.00
56.00	05600	RADIOISOTOPE	753,511	18,228	735,283	0	0	56.00
57.00	05700	CT SCAN	1,538,829	252,871	1,285,958	0	0	57.00
58.00	05800	MRI	613,789	129,076	484,713	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,379,795	433,217	1,946,578	0	0	59.00
60.00	06000	LABORATORY	9,016,579	673,182	8,343,397	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	580,989	79,611	501,378	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,582,062	202,751	2,379,311	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,412,417	241,062	2,171,355	0	0	66.00
66.01	06601	CLINICAL NUTRITION	324,435	8,352	316,083	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	1,111,120	193,771	917,349	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	534,959	45,709	489,250	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,862,080	957,428	1,904,652	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	307,519	14,299	293,220	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	119,166	4,541	114,625	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	11,114,579	155,469	10,959,110	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	6,998,334	73,530	6,924,804	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,655,541	743,032	25,912,509	0	0	73.00
74.00	07400	RENAL DIALYSIS	569,342	8,068	561,274	0	0	74.00
76.00	03950	ACUTE DIALYSIS	437,587	124,238	313,349	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	6,887,469	866,371	6,021,098	0	0	90.00
91.00	09100	EMERGENCY	6,559,272	973,235	5,586,037	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	2,137,122	285,111	1,852,011	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	109,708,340	11,139,896	98,568,444	0	0	200.00
201.00		Less Observation Beds	2,137,122	285,111	1,852,011	0	0	201.00
202.00		Total (line 200 minus line 201)	107,571,218	10,854,785	96,716,433	0	0	202.00

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

Provider CCN: 14-0046

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

Worksheet C Part II Date/Time Prepared: 5/28/2019 11:42 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)	Title XIX	
					Hospital	PPS
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	11,457,746	67,200,672	0.170500		50.00
51.00	05100 RECOVERY ROOM	712,128	9,795,516	0.072699		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	4,069,943	13,552,385	0.300312		52.00
53.00	05300 ANESTHESIOLOGY	413,972	14,201,409	0.029150		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,273,765	21,069,118	0.250308		54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	1,284,290	4,912,935	0.261410		55.00
56.00	05600 RADIOISOTOPE	753,511	9,127,839	0.082551		56.00
57.00	05700 CT SCAN	1,538,829	52,671,522	0.029216		57.00
58.00	05800 MRI	613,789	9,435,128	0.065054		58.00
59.00	05900 CARDIAC CATHETERIZATION	2,379,795	33,981,892	0.070031		59.00
60.00	06000 LABORATORY	9,016,579	79,948,278	0.112780		60.00
64.00	06400 INTRAVENOUS THERAPY	580,989	1,353,791	0.429157		64.00
65.00	06500 RESPIRATORY THERAPY	2,582,062	17,160,995	0.150461		65.00
66.00	06600 PHYSICAL THERAPY	2,412,417	8,489,399	0.284168		66.00
66.01	06601 CLINICAL NUTRITION	324,435	69,480	4.669473		66.01
67.00	06700 OCCUPATIONAL THERAPY	1,111,120	3,363,507	0.330346		67.00
68.00	06800 SPEECH PATHOLOGY	534,959	1,114,614	0.479950		68.00
69.00	06900 ELECTROCARDIOLOGY	2,862,080	19,767,737	0.144785		69.00
69.01	06901 CARDIAC REHABILITATION	307,519	749,655	0.410214		69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	119,166	264,780	0.450057		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	11,114,579	10,232,912	1.086160		71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	6,998,334	20,834,890	0.335895		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	26,655,541	78,118,216	0.341221		73.00
74.00	07400 RENAL DIALYSIS	569,342	1,483,360	0.383819		74.00
76.00	03950 ACUTE DIALYSIS	437,587	4,639,304	0.094322		76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	6,887,469	14,180,206	0.485710		90.00
91.00	09100 EMERGENCY	6,559,272	32,468,754	0.202018		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	2,137,122	2,102,449	1.016492		92.00
200.00	Subtotal (sum of lines 50 thru 199)	109,708,340	532,290,743			200.00
201.00	Less Observation Beds	2,137,122	0			201.00
202.00	Total (line 200 minus line 201)	107,571,218	532,290,743			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-0046		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part I Date/Time Prepared: 5/28/2019 11:42 am	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	3,869,351	0	3,869,351	25,867	149.59	30.00
31.00	INTENSIVE CARE UNIT	1,087,107		1,087,107	2,392	454.48	31.00
41.00	SUBPROVIDER - IRF	519,204	0	519,204	1,549	335.19	41.00
43.00	NURSERY	74,556		74,556	2,063	36.14	43.00
200.00	Total (lines 30 through 199)	5,550,218		5,550,218	31,871		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	13,223	1,978,029				
31.00	INTENSIVE CARE UNIT	1,362	619,002				
41.00	SUBPROVIDER - IRF	1,240	415,636				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	15,825	3,012,667				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Prepared: 5/28/2019 11:42 am
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Cost Center Description		Title XVIII			Hospital	PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	2,506,767	67,200,672	0.037303	19,963,791	744,709	50.00
51.00	05100 RECOVERY ROOM	23,466	9,795,516	0.002396	2,285,565	5,476	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	601,694	13,552,385	0.044398	10,370	460	52.00
53.00	05300 ANESTHESIOLOGY	35,295	14,201,409	0.002485	3,016,484	7,496	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,448,922	21,069,118	0.068770	2,958,686	203,469	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	40,600	4,912,935	0.008264	0	0	55.00
56.00	05600 RADIOISOTOPE	18,228	9,127,839	0.001997	1,281,585	2,559	56.00
57.00	05700 CT SCAN	252,871	52,671,522	0.004801	7,885,800	37,860	57.00
58.00	05800 MRI	129,076	9,435,128	0.013680	907,300	12,412	58.00
59.00	05900 CARDIAC CATHETERIZATION	433,217	33,981,892	0.012748	6,889,011	87,821	59.00
60.00	06000 LABORATORY	673,182	79,948,278	0.008420	18,189,644	153,157	60.00
64.00	06400 INTRAVENOUS THERAPY	79,611	1,353,791	0.058806	1,560	92	64.00
65.00	06500 RESPIRATORY THERAPY	202,751	17,160,995	0.011815	8,153,336	96,332	65.00
66.00	06600 PHYSICAL THERAPY	241,062	8,489,399	0.028396	3,032,063	86,098	66.00
66.01	06601 CLINICAL NUTRITION	8,352	69,480	0.120207	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	193,771	3,363,507	0.057610	901,343	51,926	67.00
68.00	06800 SPEECH PATHOLOGY	45,709	1,114,614	0.041009	205,165	8,414	68.00
69.00	06900 ELECTROCARDIOLOGY	957,428	19,767,737	0.048434	6,021,570	291,649	69.00
69.01	06901 CARDIAC REHABILITATION	14,299	749,655	0.019074	67,245	1,283	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	4,541	264,780	0.017150	1,065	18	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	155,469	10,232,912	0.015193	3,745,085	56,899	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	73,530	20,834,890	0.003529	6,086,313	21,479	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	743,032	78,118,216	0.009512	16,016,845	152,352	73.00
74.00	07400 RENAL DIALYSIS	8,068	1,483,360	0.005439	901,970	4,906	74.00
76.00	03950 ACUTE DIALYSIS	124,238	4,639,304	0.026779	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	866,371	14,180,206	0.061097	1,985	121	90.00
91.00	09100 EMERGENCY	973,235	32,468,754	0.029975	4,573,197	137,082	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	285,111	2,102,449	0.135609	146,530	19,871	92.00
200.00	Total (lines 50 through 199)	11,139,896	532,290,743		113,243,508	2,183,941	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part III Date/Time Prepared: 5/28/2019 11:42 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	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00	
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	25,867	0.00	13,223	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	2,392	0.00	1,362	31.00	
41.00	04100	SUBPROVIDER - IRF	0	0	1,549	0.00	1,240	41.00	
43.00	04300	NURSERY		0	2,063	0.00	0	43.00	
200.00		Total (lines 30 through 199)		0	31,871		15,825	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
41.00	04100	SUBPROVIDER - IRF	0						41.00
43.00	04300	NURSERY	0						43.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/28/2019 11:42 am
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Cost Center Description	Title XVIII					Hospital		PPS	
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health				
	1.00	2A	2.00	3A	3.00				
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
76.00	03950	ACUTE DIALYSIS	0	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/28/2019 11:42 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		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	67,200,672	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	9,795,516	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	13,552,385	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	14,201,409	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	21,069,118	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	4,912,935	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	9,127,839	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	52,671,522	0.000000	57.00
58.00	05800	MRI	0	0	0	9,435,128	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	33,981,892	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	79,948,278	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,353,791	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	17,160,995	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,489,399	0.000000	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	69,480	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,363,507	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,114,614	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	19,767,737	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	749,655	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	264,780	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	10,232,912	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	20,834,890	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	78,118,216	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,483,360	0.000000	74.00
76.00	03950	ACUTE DIALYSIS	0	0	0	4,639,304	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	14,180,206	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	32,468,754	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	2,102,449	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	532,290,743		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/28/2019 11:42 am
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Cost Center Description		Title XVIII				Hospital	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PPS
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	19,963,791	0	18,973,693	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	2,285,565	0	3,505,521	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	10,370	0	9,090	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	3,016,484	0	2,660,345	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	2,958,686	0	5,428,006	0	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	1,281,585	0	3,437,697	0	56.00
57.00	05700 CT SCAN	0.000000	7,885,800	0	14,654,550	0	57.00
58.00	05800 MRI	0.000000	907,300	0	2,644,980	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	6,889,011	0	5,727,275	0	59.00
60.00	06000 LABORATORY	0.000000	18,189,644	0	11,392,377	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	1,560	0	216,673	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	8,153,336	0	786,182	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	3,032,063	0	95,575	0	66.00
66.01	06601 CLINICAL NUTRITION	0.000000	0	0	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.000000	901,343	0	30,095	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	205,165	0	9,105	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	6,021,570	0	6,050,752	0	69.00
69.01	06901 CARDIAC REHABILITATION	0.000000	67,245	0	305,805	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	1,065	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.000000	3,745,085	0	2,035,864	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	6,086,313	0	4,977,085	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	16,016,845	0	29,158,852	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	901,970	0	0	0	74.00
76.00	03950 ACUTE DIALYSIS	0.000000	0	0	93,630	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	1,985	0	1,994,062	0	90.00
91.00	09100 EMERGENCY	0.000000	4,573,197	0	10,731,024	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0.000000	146,530	0	837,084	0	92.00
200.00	Total (lines 50 through 199)		113,243,508	0	125,755,322	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/28/2019 11:42 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.170500	18,973,693	0	0	3,235,015	50.00
51.00	05100 RECOVERY ROOM	0.072699	3,505,521	0	0	254,848	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.300312	9,090	0	0	2,730	52.00
53.00	05300 ANESTHESIOLOGY	0.029150	2,660,345	0	0	77,549	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.250308	5,428,006	0	0	1,358,673	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.261410	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0.082551	3,437,697	0	0	283,785	56.00
57.00	05700 CT SCAN	0.029216	14,654,550	0	0	428,147	57.00
58.00	05800 MRI	0.065054	2,644,980	0	0	172,067	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.070031	5,727,275	0	0	401,087	59.00
60.00	06000 LABORATORY	0.112780	11,392,377	0	0	1,284,832	60.00
64.00	06400 INTRAVENOUS THERAPY	0.429157	216,673	0	0	92,987	64.00
65.00	06500 RESPIRATORY THERAPY	0.150461	786,182	0	0	118,290	65.00
66.00	06600 PHYSICAL THERAPY	0.284168	95,575	0	0	27,159	66.00
66.01	06601 CLINICAL NUTRITION	4.669473	0	0	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.330346	30,095	0	0	9,942	67.00
68.00	06800 SPEECH PATHOLOGY	0.479950	9,105	0	0	4,370	68.00
69.00	06900 ELECTROCARDIOLOGY	0.144785	6,050,752	0	0	876,058	69.00
69.01	06901 CARDIAC REHABILITATION	0.410214	305,805	0	0	125,445	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.450057	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	1.086160	2,035,864	0	0	2,211,274	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.335895	4,977,085	0	0	1,671,778	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.341221	29,158,852	910	187,280	9,949,613	73.00
74.00	07400 RENAL DIALYSIS	0.383819	0	0	0	0	74.00
76.00	03950 ACUTE DIALYSIS	0.094322	93,630	0	0	8,831	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.485710	1,994,062	0	0	968,536	90.00
91.00	09100 EMERGENCY	0.202018	10,731,024	0	0	2,167,860	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	1.016492	837,084	0	0	850,889	92.00
200.00	Subtotal (see instructions)		125,755,322	910	187,280	26,581,765	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00	Net Charges (line 200 - line 201)		125,755,322	910	187,280	26,581,765	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/28/2019 11:42 am
		Title XVIII	Hospital	PPS

Cost Center Description	Costs				
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
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	311	63,904	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	ACUTE DIALYSIS	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	92.00
200.00		Subtotal (see instructions)	311	63,904	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	311	63,904	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 14-0046 Component CCN: 14-T046		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part II Date/Time Prepared: 5/28/2019 11:42 am	
			Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,506,767	67,200,672	0.037303	4,045	151	50.00
51.00	05100	RECOVERY ROOM	23,466	9,795,516	0.002396	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	601,694	13,552,385	0.044398	0	0	52.00
53.00	05300	ANESTHESIOLOGY	35,295	14,201,409	0.002485	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,448,922	21,069,118	0.068770	12,125	834	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	40,600	4,912,935	0.008264	0	0	55.00
56.00	05600	RADIOISOTOPE	18,228	9,127,839	0.001997	0	0	56.00
57.00	05700	CT SCAN	252,871	52,671,522	0.004801	13,550	65	57.00
58.00	05800	MRI	129,076	9,435,128	0.013680	3,000	41	58.00
59.00	05900	CARDIAC CATHETERIZATION	433,217	33,981,892	0.012748	0	0	59.00
60.00	06000	LABORATORY	673,182	79,948,278	0.008420	97,404	820	60.00
64.00	06400	INTRAVENOUS THERAPY	79,611	1,353,791	0.058806	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	202,751	17,160,995	0.011815	136,005	1,607	65.00
66.00	06600	PHYSICAL THERAPY	241,062	8,489,399	0.028396	1,718,952	48,811	66.00
66.01	06601	CLINICAL NUTRITION	8,352	69,480	0.120207	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	193,771	3,363,507	0.057610	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	45,709	1,114,614	0.041009	202,263	8,295	68.00
69.00	06900	ELECTROCARDIOLOGY	957,428	19,767,737	0.048434	7,615	369	69.00
69.01	06901	CARDIAC REHABILITATION	14,299	749,655	0.019074	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	4,541	264,780	0.017150	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	155,469	10,232,912	0.015193	19,600	298	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	73,530	20,834,890	0.003529	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	743,032	78,118,216	0.009512	150,272	1,429	73.00
74.00	07400	RENAL DIALYSIS	8,068	1,483,360	0.005439	9,310	51	74.00
76.00	03950	ACUTE DIALYSIS	124,238	4,639,304	0.026779	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	866,371	14,180,206	0.061097	0	0	90.00
91.00	09100	EMERGENCY	973,235	32,468,754	0.029975	138,276	4,145	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	2,102,449	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	10,854,785	532,290,743		2,512,417	66,916	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0046 Component CCN: 14-T046	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/28/2019 11:42 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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	03950	ACUTE DIALYSIS	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0046 Component CCN: 14-T046	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/28/2019 11:42 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		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	67,200,672	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	9,795,516	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	13,552,385	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	14,201,409	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	21,069,118	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	4,912,935	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	9,127,839	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	52,671,522	0.000000	57.00
58.00	05800	MRI	0	0	0	9,435,128	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	33,981,892	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	79,948,278	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,353,791	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	17,160,995	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,489,399	0.000000	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	69,480	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,363,507	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,114,614	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	19,767,737	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	749,655	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	264,780	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	10,232,912	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	20,834,890	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	78,118,216	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,483,360	0.000000	74.00
76.00	03950	ACUTE DIALYSIS	0	0	0	4,639,304	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	14,180,206	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	32,468,754	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	2,102,449	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	532,290,743		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0046 Component CCN: 14-T046		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part IV Date/Time Prepared: 5/28/2019 11:42 am	
			Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	4,045	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	12,125	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	13,550	0	0	0	57.00
58.00	05800	MRI	0.000000	3,000	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	97,404	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	136,005	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,718,952	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	202,263	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	7,615	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	19,600	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	150,272	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	9,310	0	0	0	74.00
76.00	03950	ACUTE DIALYSIS	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	138,276	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)		2,512,417	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-0046		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part I Date/Time Prepared: 5/28/2019 11:42 am	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	3,869,351	0	3,869,351	25,867	149.59	30.00
31.00	INTENSIVE CARE UNIT	1,087,107		1,087,107	2,392	454.48	31.00
41.00	SUBPROVIDER - IRF	519,204	0	519,204	1,549	335.19	41.00
43.00	NURSERY	74,556		74,556	2,063	36.14	43.00
200.00	Total (lines 30 through 199)	5,550,218		5,550,218	31,871		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	1,569	234,707				
31.00	INTENSIVE CARE UNIT	387	175,884				
41.00	SUBPROVIDER - IRF	55	18,435				
43.00	NURSERY	805	29,093				
200.00	Total (lines 30 through 199)	2,816	458,119				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Prepared: 5/28/2019 11:42 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
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2,506,767	67,200,672	0.037303	0	0 50.00
51.00	05100 RECOVERY ROOM	23,466	9,795,516	0.002396	0	0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	601,694	13,552,385	0.044398	0	0 52.00
53.00	05300 ANESTHESIOLOGY	35,295	14,201,409	0.002485	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,448,922	21,069,118	0.068770	0	0 54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	40,600	4,912,935	0.008264	0	0 55.00
56.00	05600 RADIOISOTOPE	18,228	9,127,839	0.001997	0	0 56.00
57.00	05700 CT SCAN	252,871	52,671,522	0.004801	0	0 57.00
58.00	05800 MRI	129,076	9,435,128	0.013680	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	433,217	33,981,892	0.012748	0	0 59.00
60.00	06000 LABORATORY	673,182	79,948,278	0.008420	0	0 60.00
64.00	06400 INTRAVENOUS THERAPY	79,611	1,353,791	0.058806	0	0 64.00
65.00	06500 RESPIRATORY THERAPY	202,751	17,160,995	0.011815	0	0 65.00
66.00	06600 PHYSICAL THERAPY	241,062	8,489,399	0.028396	0	0 66.00
66.01	06601 CLINICAL NUTRITION	8,352	69,480	0.120207	0	0 66.01
67.00	06700 OCCUPATIONAL THERAPY	193,771	3,363,507	0.057610	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	45,709	1,114,614	0.041009	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	957,428	19,767,737	0.048434	0	0 69.00
69.01	06901 CARDIAC REHABILITATION	14,299	749,655	0.019074	0	0 69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	4,541	264,780	0.017150	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	155,469	10,232,912	0.015193	0	0 71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	73,530	20,834,890	0.003529	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	743,032	78,118,216	0.009512	0	0 73.00
74.00	07400 RENAL DIALYSIS	8,068	1,483,360	0.005439	0	0 74.00
76.00	03950 ACUTE DIALYSIS	124,238	4,639,304	0.026779	0	0 76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	866,371	14,180,206	0.061097	0	0 90.00
91.00	09100 EMERGENCY	973,235	32,468,754	0.029975	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	285,111	2,102,449	0.135609	0	0 92.00
200.00	Total (lines 50 through 199)	11,139,896	532,290,743		0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part III Date/Time Prepared: 5/28/2019 11:42 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	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00	
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	25,867	0.00	1,569	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	2,392	0.00	387	31.00	
41.00	04100	SUBPROVIDER - IRF	0	0	1,549	0.00	55	41.00	
43.00	04300	NURSERY		0	2,063	0.00	805	43.00	
200.00		Total (lines 30 through 199)		0	31,871		2,816	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
41.00	04100	SUBPROVIDER - IRF	0						41.00
43.00	04300	NURSERY	0						43.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/28/2019 11:42 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	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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 03950 ACUTE DIALYSIS	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	0	92.00
200.00 Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/28/2019 11:42 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		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	67,200,672	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	9,795,516	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	13,552,385	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	14,201,409	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	21,069,118	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	4,912,935	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	9,127,839	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	52,671,522	0.000000	57.00
58.00	05800	MRI	0	0	0	9,435,128	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	33,981,892	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	79,948,278	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,353,791	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	17,160,995	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,489,399	0.000000	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	69,480	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,363,507	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,114,614	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	19,767,737	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	749,655	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	264,780	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	10,232,912	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	20,834,890	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	78,118,216	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,483,360	0.000000	74.00
76.00	03950	ACUTE DIALYSIS	0	0	0	4,639,304	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	14,180,206	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	32,468,754	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	2,102,449	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	532,290,743		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/28/2019 11:42 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	
ANCILLARY SERVICE COST CENTERS							
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	03950 ACUTE DIALYSIS	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
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: 14-0046 Component CCN: 14-T046		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part II Date/Time Prepared: 5/28/2019 11:42 am	
			Title XIX		Subprovider - IRF		PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,506,767	67,200,672	0.037303	0	0	50.00
51.00	05100	RECOVERY ROOM	23,466	9,795,516	0.002396	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	601,694	13,552,385	0.044398	0	0	52.00
53.00	05300	ANESTHESIOLOGY	35,295	14,201,409	0.002485	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,448,922	21,069,118	0.068770	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	40,600	4,912,935	0.008264	0	0	55.00
56.00	05600	RADIOISOTOPE	18,228	9,127,839	0.001997	0	0	56.00
57.00	05700	CT SCAN	252,871	52,671,522	0.004801	0	0	57.00
58.00	05800	MRI	129,076	9,435,128	0.013680	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	433,217	33,981,892	0.012748	0	0	59.00
60.00	06000	LABORATORY	673,182	79,948,278	0.008420	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	79,611	1,353,791	0.058806	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	202,751	17,160,995	0.011815	0	0	65.00
66.00	06600	PHYSICAL THERAPY	241,062	8,489,399	0.028396	0	0	66.00
66.01	06601	CLINICAL NUTRITION	8,352	69,480	0.120207	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	193,771	3,363,507	0.057610	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	45,709	1,114,614	0.041009	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	957,428	19,767,737	0.048434	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	14,299	749,655	0.019074	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	4,541	264,780	0.017150	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	155,469	10,232,912	0.015193	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	73,530	20,834,890	0.003529	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	743,032	78,118,216	0.009512	0	0	73.00
74.00	07400	RENAL DIALYSIS	8,068	1,483,360	0.005439	0	0	74.00
76.00	03950	ACUTE DIALYSIS	124,238	4,639,304	0.026779	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	866,371	14,180,206	0.061097	0	0	90.00
91.00	09100	EMERGENCY	973,235	32,468,754	0.029975	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	2,102,449	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	10,854,785	532,290,743		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0046 Component CCN: 14-T046	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/28/2019 11:42 am
	Title XIX	Subprovider - IRF	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
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 03950 ACUTE DIALYSIS	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	0	92.00
200.00 Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0046 Component CCN: 14-T046	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/28/2019 11:42 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		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	67,200,672	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	9,795,516	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	13,552,385	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	14,201,409	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	21,069,118	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	4,912,935	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	9,127,839	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	52,671,522	0.000000	57.00
58.00	05800	MRI	0	0	0	9,435,128	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	33,981,892	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	79,948,278	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,353,791	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	17,160,995	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,489,399	0.000000	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	69,480	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,363,507	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,114,614	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	19,767,737	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	749,655	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	264,780	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	10,232,912	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	20,834,890	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	78,118,216	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,483,360	0.000000	74.00
76.00	03950	ACUTE DIALYSIS	0	0	0	4,639,304	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	14,180,206	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	32,468,754	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	2,102,449	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	532,290,743		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0046 Component CCN: 14-T046	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/28/2019 11:42 am
Title XIX		Subprovider - IRF	PPS

Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	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	03950	ACUTE DIALYSIS	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
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: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/28/2019 11:42 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		25,867	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		25,867	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.		23,961	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		0	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)		13,223	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		29,003,742	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)		29,003,742	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		35,942,421	28.00
29.00	Private room charges (excluding swing-bed charges)		35,942,421	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)		0.806950	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		1,500.04	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)		1,500.04	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		1,210.46	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		29,003,832	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		-90	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,121.26	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		14,826,421	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)		14,826,421	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/28/2019 11:42 am		
Cost Center Description			Title XVIII		Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	5,687,776	2,392	2,377.83	1,362	3,238,604	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)					23,741,899	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					41,806,924	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)					2,597,031	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,183,941	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					4,780,972	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					37,025,952	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					1,906	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,121.26	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,137,122	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0046		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/28/2019 11:42 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	3,869,351	29,003,742	0.133409	2,137,122	285,111	90.00
91.00	Nursing School cost	0	29,003,742	0.000000	2,137,122	0	91.00
92.00	Allied health cost	0	29,003,742	0.000000	2,137,122	0	92.00
93.00	All other Medical Education	0	29,003,742	0.000000	2,137,122	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0046 Component CCN: 14-T046	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/28/2019 11:42 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,549 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,549 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)			1,549 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)			1,240 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			2,381,615 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,381,615 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			2,381,615 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,537.52 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,906,525 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)			1,906,525 41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1	
				Component CCN: 14-T046	Date/Time Prepared: 5/28/2019 11:42 am		
				Title XVIII	Subprovider - IRF	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
Intensive Care Type Inpatient Hospital Units							
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
Cost Center Description							
						1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						726,700	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						2,633,225	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)						415,636	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						66,916	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						482,552	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						2,150,673	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: 14-0046 Component CCN: 14-T046		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/28/2019 11:42 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	519,204	2,381,615	0.218005	0	0	90.00
91.00	Nursing School cost	0	2,381,615	0.000000	0	0	91.00
92.00	Allied health cost	0	2,381,615	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,381,615	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/28/2019 11:42 am
Cost Center Description		Title XIX	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		25,867	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		25,867	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)		23,961	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)		1,569	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)		2,063	15.00
16.00	Nursery days (title V or XIX only)		805	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		29,003,742	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)		29,003,742	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		29,003,742	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,121.26	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,759,257	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)		1,759,257	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/28/2019 11:42 am		
Cost Center Description			Title XIX		Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	883,095	2,063	428.06	805	344,588	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	5,687,776	2,392	2,377.83	387	920,220	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)					3,024,065	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)					439,684	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)					439,684	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,584,381	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					1,906	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,121.26	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,137,122	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0046		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/28/2019 11:42 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	3,869,351	29,003,742	0.133409	2,137,122	285,111	90.00
91.00	Nursing School cost	0	29,003,742	0.000000	2,137,122	0	91.00
92.00	Allied health cost	0	29,003,742	0.000000	2,137,122	0	92.00
93.00	All other Medical Education	0	29,003,742	0.000000	2,137,122	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0046 Component CCN: 14-T046	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/28/2019 11:42 am
		Title XIX	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,549 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,549 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)			1,549 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)			55 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)			2,063 15.00
16.00	Nursery days (title V or XIX only)			805 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			2,381,615 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,381,615 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			2,381,615 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,537.52 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			84,564 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)			84,564 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0046 Component CCN: 14-T046		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/28/2019 11:42 am	
		Title XIX		Subprovider - IRF		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)				0		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				84,564		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)				18,435		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)				18,435		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				66,129		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: 14-0046 Component CCN: 14-T046		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/28/2019 11:42 am	
		Title XIX		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	519,204	2,381,615	0.218005	0	0	90.00
91.00	Nursing School cost	0	2,381,615	0.000000	0	0	91.00
92.00	Allied health cost	0	2,381,615	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,381,615	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/28/2019 11:42 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		17,947,460	30.00
31.00	03100	INTENSIVE CARE UNIT		2,809,350	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.170500	19,963,791	50.00
51.00	05100	RECOVERY ROOM	0.072699	2,285,565	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.300312	10,370	52.00
53.00	05300	ANESTHESIOLOGY	0.029150	3,016,484	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.250308	2,958,686	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.261410	0	55.00
56.00	05600	RADIOISOTOPE	0.082551	1,281,585	56.00
57.00	05700	CT SCAN	0.029216	7,885,800	57.00
58.00	05800	MRI	0.065054	907,300	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.070031	6,889,011	59.00
60.00	06000	LABORATORY	0.112780	18,189,644	60.00
64.00	06400	INTRAVENOUS THERAPY	0.429157	1,560	64.00
65.00	06500	RESPIRATORY THERAPY	0.150461	8,153,336	65.00
66.00	06600	PHYSICAL THERAPY	0.284168	3,032,063	66.00
66.01	06601	CLINICAL NUTRITION	4.669473	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.330346	901,343	67.00
68.00	06800	SPEECH PATHOLOGY	0.479950	205,165	68.00
69.00	06900	ELECTROCARDIOLOGY	0.146184	6,021,570	69.00
69.01	06901	CARDIAC REHABILITATION	0.416872	67,245	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.458985	1,065	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1.086160	3,745,085	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.335895	6,086,313	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.341221	16,016,845	73.00
74.00	07400	RENAL DIALYSIS	0.405746	901,970	74.00
76.00	03950	ACUTE DIALYSIS	0.094322	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.485710	1,985	90.00
91.00	09100	EMERGENCY	0.202018	4,573,197	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	1.016492	146,530	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		113,243,508	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)		113,243,508	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0046 Component CCN: 14-T046	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/28/2019 11:42 am	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
41.00	04100 SUBPROVIDER - IRF		1,479,489		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.170500	4,045	690	50.00
51.00	05100 RECOVERY ROOM	0.072699	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.300312	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.029150	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.250308	12,125	3,035	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.261410	0	0	55.00
56.00	05600 RADIOISOTOPE	0.082551	0	0	56.00
57.00	05700 CT SCAN	0.029216	13,550	396	57.00
58.00	05800 MRI	0.065054	3,000	195	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.070031	0	0	59.00
60.00	06000 LABORATORY	0.112780	97,404	10,985	60.00
64.00	06400 INTRAVENOUS THERAPY	0.429157	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.150461	136,005	20,463	65.00
66.00	06600 PHYSICAL THERAPY	0.284168	1,718,952	488,471	66.00
66.01	06601 CLINICAL NUTRITION	4.669473	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.330346	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.479950	202,263	97,076	68.00
69.00	06900 ELECTROCARDIOLOGY	0.146184	7,615	1,113	69.00
69.01	06901 CARDIAC REHABILITATION	0.416872	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.458985	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	1.086160	19,600	21,289	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.335895	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.341221	150,272	51,276	73.00
74.00	07400 RENAL DIALYSIS	0.405746	9,310	3,777	74.00
76.00	03950 ACUTE DIALYSIS	0.094322	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.485710	0	0	90.00
91.00	09100 EMERGENCY	0.202018	138,276	27,934	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	1.016492	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		2,512,417	726,700	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)		2,512,417		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/28/2019 11:42 am
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		21,948,326	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		6,405,276	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)		850,708	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)		118.78	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		5.47	30.00
31.00	Percentage of Medicaid patient days (see instructions)		22.40	31.00
32.00	Sum of lines 30 and 31		27.87	32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.21	33.00
34.00	Disproportionate share adjustment (see instructions)		865,494	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/28/2019 11:42 am
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)	6,766,695,164	8,272,872,447	35.00
35.01	Factor 3 (see instructions)	0.000146112	0.000142692	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	988,697	1,180,475	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	739,491	297,545	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,037,036		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	46.00
47.00	Subtotal (see instructions)		31,106,840	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	48.00
				Amount
				1.00
49.00	Total payment for inpatient operating costs (see instructions)		31,106,840	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,440,444	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		6,322	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)		33,553,606	59.00
60.00	Primary payer payments		5,334	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		33,548,272	61.00
62.00	Deductibles billed to program beneficiaries		3,178,812	62.00
63.00	Coinurance billed to program beneficiaries		34,170	63.00
64.00	Allowable bad debts (see instructions)		696,391	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		452,654	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		489,550	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		30,787,944	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-53,873	70.93
70.94	HRR adjustment amount (see instructions)		-520,263	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/28/2019 11:42 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)		30,213,808	71.00
71.01	Sequestration adjustment (see instructions)		604,276	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		29,683,967	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)		-74,435	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,215,515	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
			Prior to 10/1	On/After 10/1
			1.00	2.00
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)		0.9990591931	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.9810	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0046

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/28/2019 11:42 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	21,948,326	0	21,948,326		21,948,326	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	6,405,276	0		6,405,276	6,405,276	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	850,708	0	636,283	214,425	850,708	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1221	0.1221	0.1221	0.1221		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	865,494	0	669,973	195,521	865,494	11.00
11.01	Uncompensated care payments	36.00	1,037,036	0	5,061,115,814	2,085,223,554	7,146,339,368	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	31,106,840	0	-2,060,931,936	2,092,038,776	31,106,840	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	31,106,840	0	-2,060,931,936	2,092,038,776	31,106,840	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,440,444	0	1,893,745	546,699	2,440,444	16.00
17.00	Special add-on payments for new technologies	54.00	6,322	0	6,322	0	6,322	17.00
17.01	Net organ acquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0046

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/28/2019 11:42 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	-2,059,031,869	2,092,585,475	33,553,606	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	2,291,242	0	1,773,714	517,528	2,291,242	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	149,202	0	120,031	29,171	149,202	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	2,440,444	0	1,893,745	546,699	2,440,444	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: 14-0046		Period: From 01/01/2018 To 12/31/2018		Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/28/2019 11:42 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	21,948,326	21,948,326		21,948,326	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	6,405,276		6,405,276	6,405,276	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	850,708	702,394	148,315	850,709	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1221	0.1221	0.1221		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	865,494	669,973	195,521	865,494	11.00
11.01	Uncompensated care payments	36.00	1,037,036	739,491	297,545	1,037,036	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	31,106,840	24,060,183	7,046,657	31,106,840	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	31,106,840	24,060,183	7,046,657	31,106,840	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,440,444	1,893,745	546,699	2,440,444	16.00
17.00	Special add-on payments for new technologies	54.00	6,322	6,322	0	6,322	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			25,960,250	7,593,356	33,553,606	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/28/2019 11:42 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	2,291,242	1,773,714	517,528	2,291,242	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	149,202	120,031	29,171	149,202	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	2,440,444	1,893,745	546,699	2,440,444	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	-53,873	-20,655	-33,218	-53,873	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-520,263	-417,138	-103,125	-520,263	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/28/2019 11:42 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		64,215	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		26,581,765	2.00
3.00	OPPS payments		23,704,528	3.00
4.00	Outlier payment (see instructions)		178,356	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)		64,215	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		188,190	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)		188,190	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		188,190	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		123,975	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)		64,215	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)		23,882,884	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		4,346,788	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)		19,600,311	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)		19,600,311	30.00
31.00	Primary payer payments		5,819	31.00
32.00	Subtotal (line 30 minus line 31)		19,594,492	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		673,824	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		437,986	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		445,754	36.00
37.00	Subtotal (see instructions)		20,032,478	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-206	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)		20,032,684	40.00
40.01	Sequestration adjustment (see instructions)		400,654	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		19,453,439	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		178,591	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0046

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

Worksheet E-1
Part I
Date/Time Prepared:
5/28/2019 11:42 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		29,164,913		19,172,989	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		407,906		251,435	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	05/31/2018	111,148	05/31/2018	29,015	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)		111,148		29,015	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)		29,683,967		19,453,439	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		178,591	6.01	
6.02	SETTLEMENT TO PROGRAM		74,435		0	6.02	
7.00	Total Medicare program liability (see instructions)		29,609,532		19,632,030	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: 14-0046 Component CCN: 14-T046	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part I Date/Time Prepared: 5/28/2019 11:42 am	
		Title XVIII	Subprovider - IRF	PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider				0
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		2,293,732		0
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)				0
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	05/31/2018	2,582		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		2,582		0
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)		2,296,314		0
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)				0
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				0
6.01	SETTLEMENT TO PROVIDER		0		0
6.02	SETTLEMENT TO PROGRAM		75,670		0
7.00	Total Medicare program liability (see instructions)		2,220,644		0
				Contractor Number	NPR Date (Mo/Day/Yr)
			0	1.00	2.00
8.00	Name of Contractor				0

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/28/2019 11:42 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0046 Component CCN: 14-T046	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part III Date/Time Prepared: 5/28/2019 11:42 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			2,122,936 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0065 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			28,872 3.00
4.00	Outlier Payments			118,644 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			4.243836 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			2,270,452 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			2,270,452 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			2,270,452 19.00
20.00	Deductibles			5,360 20.00
21.00	Subtotal (line 19 minus line 20)			2,265,092 21.00
22.00	Coinsurance			0 22.00
23.00	Subtotal (line 21 minus line 22)			2,265,092 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			1,340 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			871 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			1,340 26.00
27.00	Subtotal (sum of lines 23 and 25)			2,265,963 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			0 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			2,265,963 32.00
32.01	Sequestration adjustment (see instructions)			45,319 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			2,296,314 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			-75,670 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			118,644 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: 14-0046		Period: From 01/01/2018 To 12/31/2018		Worksheet G Date/Time Prepared: 5/28/2019 11:42 am	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund		
		1.00	2.00	3.00	4.00		
CURRENT ASSETS							
1.00	Cash on hand in banks	644,499	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	26,225,684	0	0	0	4.00	
5.00	Other receivable	2,098,327	0	0	0	5.00	
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00	
7.00	Inventory	4,083,951	0	0	0	7.00	
8.00	Prepaid expenses	1,430,658	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)	34,483,119	0	0	0	11.00	
FIXED ASSETS							
12.00	Land	632,759	0	0	0	12.00	
13.00	Land improvements	6,815,977	0	0	0	13.00	
14.00	Accumulated depreciation	-4,509,211	0	0	0	14.00	
15.00	Buildings	172,472,288	0	0	0	15.00	
16.00	Accumulated depreciation	-41,646,484	0	0	0	16.00	
17.00	Leasehold improvements	17,587,888	0	0	0	17.00	
18.00	Accumulated depreciation	-5,267,711	0	0	0	18.00	
19.00	Fixed equipment	15,370,958	0	0	0	19.00	
20.00	Accumulated depreciation	-6,310,702	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	49,857,103	0	0	0	23.00	
24.00	Accumulated depreciation	-38,202,816	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)	166,800,049	0	0	0	30.00	
OTHER ASSETS							
31.00	Investments	3,839,218	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	2,567,542	414,435	0	0	34.00	
35.00	Total other assets (sum of lines 31-34)	6,406,760	414,435	0	0	35.00	
36.00	Total assets (sum of lines 11, 30, and 35)	207,689,928	414,435	0	0	36.00	
CURRENT LIABILITIES							
37.00	Accounts payable	7,297,035	0	0	0	37.00	
38.00	Salaries, wages, and fees payable	5,856,007	0	0	0	38.00	
39.00	Payroll taxes payable	167,142	0	0	0	39.00	
40.00	Notes and loans payable (short term)	1,856,886	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	-68,841,431	0	0	0	44.00	
45.00	Total current liabilities (sum of lines 37 thru 44)	-53,664,361	0	0	0	45.00	
LONG TERM LIABILITIES							
46.00	Mortgage payable	165,587,082	0	0	0	46.00	
47.00	Notes payable	0	0	0	0	47.00	
48.00	Unsecured loans	-897,445	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)	164,689,637	0	0	0	50.00	
51.00	Total liabilities (sum of lines 45 and 50)	111,025,276	0	0	0	51.00	
CAPITAL ACCOUNTS							
52.00	General fund balance	96,664,652				52.00	
53.00	Specific purpose fund		414,435			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)	96,664,652	414,435	0	0	59.00	
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	207,689,928	414,435	0	0	60.00	

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0046

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

Worksheet G-1

Date/Time Prepared:
5/28/2019 11:42 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		67,087,278		430,992		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		26,669,674				2.00
3.00	Total (sum of line 1 and line 2)		93,756,952		430,992		3.00
4.00	ADDITIONS (CREDIT ADJUSTMENTS)	2,214,210		22,749		0	4.00
5.00	CORPORATE OFFICE	780,613		0		0	5.00
6.00	GAIN ON INVESTMENTS	0		0		0	6.00
7.00	TRANSFER FROM OTHER RELATED ORGANIZA	72,831		0		0	7.00
8.00	TRANSFERS FROM OTHER FUNDS	0		0		0	8.00
9.00	DONATIONS	0		0		0	9.00
10.00	Total additions (sum of line 4-9)		3,067,654		22,749		10.00
11.00	Subtotal (line 3 plus line 10)		96,824,606		453,741		11.00
12.00	DEDUCTIONS (DEBIT ADJUSTMENTS)	159,954		39,306		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		159,954		39,306		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		96,664,652		414,435		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	ADDITIONS (CREDIT ADJUSTMENTS)		0				4.00
5.00	CORPORATE OFFICE		0				5.00
6.00	GAIN ON INVESTMENTS		0				6.00
7.00	TRANSFER FROM OTHER RELATED ORGANIZA		0				7.00
8.00	TRANSFERS FROM OTHER FUNDS		0				8.00
9.00	DONATIONS		0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	DEDUCTIONS (DEBIT ADJUSTMENTS)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0046

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/28/2019 11:42 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	36,927,694		36,927,694	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	1,931,995		1,931,995	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)	38,859,689		38,859,689	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	6,406,741		6,406,741	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)	6,406,741		6,406,741	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	45,266,430		45,266,430	17.00
18.00	Ancillary services	216,617,166	281,220,636	497,837,802	18.00
19.00	Outpatient services	8,269,233	41,361,599	49,630,832	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NON-REIMBURSABLE PROFESSIONAL FEES	14,634,255	9,091,605	23,725,860	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	284,787,084	331,673,840	616,460,924	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		183,398,944		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)		183,398,944		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet G-3 Date/Time Prepared: 5/28/2019 11:42 am
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		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	616,460,924	1.00
2.00	Less contractual allowances and discounts on patients' accounts	414,966,981	2.00
3.00	Net patient revenues (line 1 minus line 2)	201,493,943	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	183,398,944	4.00
5.00	Net income from service to patients (line 3 minus line 4)	18,094,999	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,234,542	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	6,065	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	713,957	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	4,922	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	42,122	20.00
21.00	Rental of vending machines	13,952	21.00
22.00	Rental of hospital space	463,841	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	6,095,274	24.00
25.00	Total other income (sum of lines 6-24)	8,574,675	25.00
26.00	Total (line 5 plus line 25)	26,669,674	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)	26,669,674	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0046	Period: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III Date/Time Prepared: 5/28/2019 11:42 am
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		2,291,242	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		149,202	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)		74.66	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)		2,440,444	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00