

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: 14-0058	Period: From 10/01/2017 To 09/30/2018	Worksheet S Parts I-III Date/Time Prepared: 2/26/2019 11:50 am
--	-----------------------	---	---

PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 2/26/2019 Time: 11:50 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PASSAVANT AREA HOSPITAL (14-0058) for the cost reporting period beginning 10/01/2017 and ending 09/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

Title

Date

Cost Center Description	Title V	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	-126,314	31,980	0	0	1.00
2.00 Subprovider - IPF	0	0	99		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	0	313		0	7.00
200.00 Total	0	-126,314	32,392	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: 14-0058	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part I Date/Time Prepared: 2/26/2019 11:50 am
---	--	-----------------------	---	--

1.00 Hospital and Hospital Health Care Complex Address:	2.00 Street: 1600 WEST WALNUT	3.00 PO Box:	4.00 State: IL	5.00 Zip Code: 62650-1185	6.00 County: MORGAN	7.00	8.00	9.00	10.00
---	-------------------------------	--------------	----------------	---------------------------	---------------------	------	------	------	-------

Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
					V	XVIII	XIX

3.00 Hospital	PASSAVANT AREA HOSPITAL	140058	99914	1	07/01/1966	N	P	N	3.00
4.00 Subprovider - IPF	PASSAVANT AREA HOSPITAL	14S058	99914	4	10/01/2016	N	P	N	4.00
5.00 Subprovider - IRF									5.00
6.00 Subprovider - (Other)									6.00
7.00 Swing Beds - SNF									7.00
8.00 Swing Beds - NF									8.00
9.00 Hospital-Based SNF	PASSAVANT AREA HOSPITAL	145951	99914		10/31/1997	N	P	N	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

20.00 Cost Reporting Period (mm/dd/yyyy)	From: 1.00	To: 2.00	20.00
21.00 Type of Control (see instructions)	10/01/2017	09/30/2018	21.00
	2		
	1.00	2.00	3.00

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.	1	N		23.00

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days
	1.00	2.00	3.00	4.00	5.00	6.00
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,466	498	0	0	535	89

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0058			Period: From 10/01/2017 To 09/30/2018		Worksheet S-2 Part I Date/Time Prepared: 2/26/2019 11:50 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.	0	0	0	0	0	0	25.00	
						Urban/Rural	Date of Geogr		
						1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					1		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.					10/01/2017	09/30/2018	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.								58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criteria Code			
				1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)					N		60.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0058		Period: From 10/01/2017 To 09/30/2018		Worksheet S-2 Part I Date/Time Prepared: 2/26/2019 11:50 am	
	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0058		Period: From 10/01/2017 To 09/30/2018		Worksheet S-2 Part I Date/Time Prepared: 2/26/2019 11:50 am		
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))			
	1.00	2.00	3.00	4.00	5.00			
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))			
			1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010								
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		66.00	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))			
	1.00	2.00	3.00	4.00	5.00			
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00	
					1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				Y		70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N	N	0	71.00
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N		75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)						0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0058		Period: From 10/01/2017 To 09/30/2018		Worksheet S-2 Part I Date/Time Prepared: 2/26/2019 11:50 am			
						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	Y	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.						N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.					N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.					N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.					0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.					N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.					0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	N	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	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.					N	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: 14-0058	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part I Date/Time Prepared: 2/26/2019 11:50 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:	370,139	0	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		14H058		140.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0058		Period: From 10/01/2017 To 09/30/2018		Worksheet S-2 Part II Date/Time Prepared: 2/26/2019 11:50 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					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	01/08/2019	Y	01/08/2019		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: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet S-2
Part II
Date/Time Prepared:
2/26/2019 11:50 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	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				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
Interest Expense						
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
Purchased Services						
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
Provider-Based Physicians						
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
Home Office Costs						
36.00	Were home office costs claimed on the cost report?				N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				N	40.00
					1.00	2.00
Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICIA		RACHELL		41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-231-5544		PRACHELL@BKD.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0058	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part II Date/Time Prepared: 2/26/2019 11:50 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.	DI RECTOR		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: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet S-3
Part I
Date/Time Prepared:
2/26/2019 11:50 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	84	27,262	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)		84	27,262	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	9	3,285	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		93	30,547	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	10	3,650		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	15	5,475		0	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)		118				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: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet S-3
Part I
Date/Time Prepared:
2/26/2019 11:50 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	5,048	1,188	9,466			1.00
2.00 HMO and other (see instructions)	548	819				2.00
3.00 HMO IPF Subprovider	5	294				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	5,048	1,188	9,466			7.00
8.00 INTENSIVE CARE UNIT	668	142	1,238			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		350	788			13.00
14.00 Total (see instructions)	5,716	1,680	11,492	0.00	738.39	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	345	596	2,370	0.00	22.04	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	3,259	0	4,482	0.00	19.75	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	780.18	27.00
28.00 Observation Bed Days		141	533			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			208			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	89	140			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: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet S-3
Part I
Date/Time Prepared:
2/26/2019 11:50 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	1,502	573	3,234	1.00
2.00 HMO and other (see instructions)				138	0		2.00
3.00 HMO IPF Subprovider					0		3.00
4.00 HMO IRF Subprovider					0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0		1,502	573	3,234	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF	0.00	0		43	206	373	16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY	0.00						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: 14-0058	Period: From 10/01/2017 To 09/30/2018	Worksheet S-3 Part II Date/Time Prepared: 2/26/2019 11:50 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	44,441,345	0	44,441,345	1,676,573.49	26.51	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non-Physician-Part B		409,827	0	409,827	4,791.30	85.54	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	921,002	0	921,002	36,525.30	25.22	9.00
10.00	Excluded area salaries (see instructions)		1,590,153	0	1,590,153	59,726.94	26.62	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract Labor: Direct Patient Care		223,579	0	223,579	3,942.00	56.72	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		140,980	0	140,980	1,139.15	123.76	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		72,300	0	72,300	2,080.00	34.76	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		15,227,519	0	15,227,519			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		778,701	0	778,701			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		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		74,678	0	74,678			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)		5,015	0	5,015			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	393,554	0	393,554	7,707.34	51.06	26.00
27.00	Administrative & General	5.00	8,232,247	0	8,232,247	341,600.71	24.10	27.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet S-3
Part II
Date/Time Prepared:
2/26/2019 11:50 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		50,423	0	50,423	226.25	222.86	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,089,547	0	1,089,547	38,882.69	28.02	30.00
31.00	Laundry & Linen Service	8.00	251,783	0	251,783	17,702.64	14.22	31.00
32.00	Housekeeping	9.00	1,078,536	0	1,078,536	80,938.67	13.33	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,382,460	-889,824	492,636	22,987.23	21.43	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	889,824	889,824	65,826.54	13.52	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	724,558	0	724,558	18,780.37	38.58	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	996,682	0	996,682	23,495.05	42.42	40.00
41.00	Medical Records & Medical Records Library	16.00	905,489	0	905,489	59,870.18	15.12	41.00
42.00	Social Service	17.00	212,823	0	212,823	8,015.50	26.55	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet S-3
Part III
Date/Time Prepared:
2/26/2019 11:50 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)	44,081,941	0	44,081,941	1,672,008.44	26.36	1.00
2.00	Excluded area salaries (see instructions)	2,511,155	0	2,511,155	96,252.24	26.09	2.00
3.00	Subtotal salaries (line 1 minus line 2)	41,570,786	0	41,570,786	1,575,756.20	26.38	3.00
4.00	Subtotal other wages & related costs (see inst.)	436,859	0	436,859	7,161.15	61.00	4.00
5.00	Subtotal wage-related costs (see inst.)	15,232,534	0	15,232,534	0.00	36.64	5.00
6.00	Total (sum of lines 3 thru 5)	57,240,179	0	57,240,179	1,582,917.35	36.16	6.00
7.00	Total overhead cost (see instructions)	15,318,102	0	15,318,102	686,033.17	22.33	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0058	Period: From 10/01/2017 To 09/30/2018	Worksheet S-3 Part IV Date/Time Prepared: 2/26/2019 11:50 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			1,835,562 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0 4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			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)		10,398,617	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		23,239	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)		164,652	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		260,305	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		3,228,771	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		3,538	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		166,214	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		16,080,898	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: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet S-3
Part V
Date/Time Prepared:
2/26/2019 11:50 am

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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet S-7

Date/Time Prepared:
2/26/2019 11:50 am

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N		2.00

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1.00	2.00	3.00	4.00	
3.00	RUX	0	0	0	3.00
4.00	RUL	0	0	0	4.00
5.00	RVX	0	0	0	5.00
6.00	RVL	23	0	23	6.00
7.00	RHX	0	0	0	7.00
8.00	RHL	31	0	31	8.00
9.00	RMX	9	0	9	9.00
10.00	RML	0	0	0	10.00
11.00	RLX	0	0	0	11.00
12.00	RUC	16	0	16	12.00
13.00	RUB	78	0	78	13.00
14.00	RUA	6	0	6	14.00
15.00	RVC	387	0	387	15.00
16.00	RVB	235	0	235	16.00
17.00	RVA	391	0	391	17.00
18.00	RHC	222	0	222	18.00
19.00	RHB	296	0	296	19.00
20.00	RHA	1,122	0	1,122	20.00
21.00	RMC	40	0	40	21.00
22.00	RMB	22	0	22	22.00
23.00	RMA	156	0	156	23.00
24.00	RLB	0	0	0	24.00
25.00	RLA	0	0	0	25.00
26.00	ES3	0	0	0	26.00
27.00	ES2	0	0	0	27.00
28.00	ES1	0	0	0	28.00
29.00	HE2	5	0	5	29.00
30.00	HE1	0	0	0	30.00
31.00	HD2	5	0	5	31.00
32.00	HD1	21	0	21	32.00
33.00	HC2	0	0	0	33.00
34.00	HC1	17	0	17	34.00
35.00	HB2	65	0	65	35.00
36.00	HB1	37	0	37	36.00
37.00	LE2	0	0	0	37.00
38.00	LE1	0	0	0	38.00
39.00	LD2	0	0	0	39.00
40.00	LD1	13	0	13	40.00
41.00	LC2	0	0	0	41.00
42.00	LC1	0	0	0	42.00
43.00	LB2	0	0	0	43.00
44.00	LB1	14	0	14	44.00
45.00	CE2	0	0	0	45.00
46.00	CE1	0	0	0	46.00
47.00	CD2	0	0	0	47.00
48.00	CD1	0	0	0	48.00
49.00	CC2	0	0	0	49.00
50.00	CC1	0	0	0	50.00
51.00	CB2	0	0	0	51.00
52.00	CB1	25	0	25	52.00
53.00	CA2	4	0	4	53.00
54.00	CA1	13	0	13	54.00
55.00	SE3	0	0	0	55.00
56.00	SE2	0	0	0	56.00
57.00	SE1	0	0	0	57.00
58.00	SSC	0	0	0	58.00
59.00	SSB	0	0	0	59.00
60.00	SSA	0	0	0	60.00
61.00	IB2	0	0	0	61.00
62.00	IB1	0	0	0	62.00
63.00	IA2	0	0	0	63.00
64.00	IA1	0	0	0	64.00
65.00	BB2	0	0	0	65.00
66.00	BB1	0	0	0	66.00
67.00	BA2	0	0	0	67.00
68.00	BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet S-7

Date/Time Prepared:
2/26/2019 11:50 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	6	0	6	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		3,259	0	3,259	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
201.00	SNF SERVICES	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).		99914	99914	201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing		921,002	12.18	Y	202.00
203.00	Recruitment		0	0.00		203.00
204.00	Retention of employees		0	0.00		204.00
205.00	Training		0	0.00		205.00
206.00	OTHER (SPECIFY)		0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		7,563,154			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0058	Period: From 10/01/2017 To 09/30/2018	Worksheet S-10 Date/Time Prepared: 2/26/2019 11:50 am
---	-----------------------	---	---

			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)		0.228438	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		5,416,908	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		4,487,734	5.00	
6.00	Medicaid charges		64,950,096	6.00	
7.00	Medicaid cost (line 1 times line 6)		14,837,070	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		4,932,428	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		75,919	9.00	
10.00	Stand-alone CHIP charges		721,975	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)		164,927	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		89,008	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		5,021,436	19.00	
			Uninsured patients	Insured patients	Total (col. 1 + col. 2)
			1.00	2.00	3.00
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	2,134,336	54,659	2,188,995	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	487,563	54,659	542,222	21.00
22.00	Payments received from patients for amounts previously written off as charity care	344	0	344	22.00
23.00	Cost of charity care (line 21 minus line 22)	487,219	54,659	541,878	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)		3,799,380	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		572,962	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		881,480	27.01	
28.00	Non-Medicare bad debt expense (see instructions)		2,917,900	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		975,077	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,516,955	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		6,538,391	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet A
Date/Time Prepared:
2/26/2019 11:50 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		1,677,842	1,677,842	424,288	2,102,130	1.00
2.00	00200		2,701,568	2,701,568	45,218	2,746,786	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	393,554	15,976,081	16,369,635	0	16,369,635	4.00
5.01	00540	0	63,405	63,405	0	63,405	5.01
5.02	00550	954,464	1,986,066	2,940,530	0	2,940,530	5.02
5.03	00560	343,211	170,210	513,421	0	513,421	5.03
5.04	00570	761,754	31,840	793,594	0	793,594	5.04
5.05	00580	703,028	586,653	1,289,681	0	1,289,681	5.05
5.06	00590	5,469,790	8,733,111	14,202,901	0	14,202,901	5.06
7.00	00700	1,089,547	2,988,256	4,077,803	-153,800	3,924,003	7.00
8.00	00800	251,783	129,337	381,120	0	381,120	8.00
9.00	00900	1,078,536	192,805	1,271,341	0	1,271,341	9.00
10.00	01000	1,382,460	1,374,900	2,757,360	-1,822,716	934,644	10.00
11.00	01100	0	0	0	1,822,716	1,822,716	11.00
13.00	01300	724,558	60,640	785,198	0	785,198	13.00
15.00	01500	996,682	4,346,228	5,342,910	-4,182,076	1,160,834	15.00
16.00	01600	905,489	80,119	985,608	0	985,608	16.00
17.00	01700	212,823	28,232	241,055	0	241,055	17.00
19.00	01900	-68,489	0	-68,489	0	-68,489	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	4,403,603	2,661,720	7,065,323	-1,817	7,063,506	30.00
31.00	03100	1,407,300	152,247	1,559,547	-479	1,559,068	31.00
40.00	04000	1,269,994	243,584	1,513,578	0	1,513,578	40.00
43.00	04300	411,539	56,501	468,040	0	468,040	43.00
44.00	04400	921,002	56,294	977,296	-34	977,262	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	4,104,128	4,682,536	8,786,664	-1,756,694	7,029,970	50.00
52.00	05200	102,885	14,125	117,010	0	117,010	52.00
53.00	05300	182,154	355,103	537,257	0	537,257	53.00
54.00	05400	3,249,215	1,435,399	4,684,614	0	4,684,614	54.00
60.00	06000	2,085,474	2,411,431	4,496,905	0	4,496,905	60.00
65.00	06500	1,149,928	196,775	1,346,703	0	1,346,703	65.00
66.00	06600	3,946,743	420,194	4,366,937	0	4,366,937	66.00
68.00	06800	224,085	3,695	227,780	0	227,780	68.00
70.00	07000	6,020	1,519	7,539	0	7,539	70.00
71.00	07100	137,872	228,235	366,107	0	366,107	71.00
72.00	07200	0	0	0	1,756,694	1,756,694	72.00
73.00	07300	0	0	0	4,184,406	4,184,406	73.00
74.00	07400	20,077	70,315	90,392	0	90,392	74.00
76.00	03950	0	0	0	0	0	76.00
76.97	07697	122,879	31,781	154,660	0	154,660	76.97
76.98	07698	76,973	32,935	109,908	0	109,908	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	1,114,919	907,485	2,022,404	0	2,022,404	90.00
91.00	09100	3,985,206	2,813,240	6,798,446	0	6,798,446	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		469,506	469,506	-469,506	0	113.00
118.00		44,121,186	58,371,913	102,493,099	-153,800	102,339,299	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	320,159	29,976	350,135	153,800	503,935	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	0	17	17	0	17	194.00
200.00		44,441,345	58,401,906	102,843,251	0	102,843,251	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet A
Date/Time Prepared:
2/26/2019 11:50 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	857,716	2,959,846	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,169,797	3,916,583	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-4,066,068	12,303,567	4.00
5.01	00540	NONPATIENT TELEPHONES	-9,928	53,477	5.01
5.02	00550	DATA PROCESSING	0	2,940,530	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	513,421	5.03
5.04	00570	ADMINISTRATIVE	0	793,594	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	1,289,681	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	-4,306,013	9,896,888	5.06
7.00	00700	OPERATION OF PLANT	-18,694	3,905,309	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	381,120	8.00
9.00	00900	HOUSEKEEPING	0	1,271,341	9.00
10.00	01000	DIETARY	-65,823	868,821	10.00
11.00	01100	CAFETERIA	-584,682	1,238,034	11.00
13.00	01300	NURSING ADMINISTRATION	-835	784,363	13.00
15.00	01500	PHARMACY	0	1,160,834	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-26,189	959,419	16.00
17.00	01700	SOCIAL SERVICE	0	241,055	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	68,489	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,134,735	4,928,771	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,559,068	31.00
40.00	04000	SUBPROVIDER - IPF	-167,028	1,346,550	40.00
43.00	04300	NURSERY	0	468,040	43.00
44.00	04400	SKILLED NURSING FACILITY	0	977,262	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,281	7,032,251	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	117,010	52.00
53.00	05300	ANESTHESIOLOGY	0	537,257	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-4,116	4,680,498	54.00
60.00	06000	LABORATORY	-75,000	4,421,905	60.00
65.00	06500	RESPIRATORY THERAPY	2,803	1,349,506	65.00
66.00	06600	PHYSICAL THERAPY	-78,424	4,288,513	66.00
68.00	06800	SPEECH PATHOLOGY	0	227,780	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,539	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	366,107	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,756,694	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-33,217	4,151,189	73.00
74.00	07400	RENAL DIALYSIS	-46,324	44,068	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	154,660	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	-1,144	108,764	76.98
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-1,177,584	844,820	90.00
91.00	09100	EMERGENCY	-1,838,277	4,960,169	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-12,532,995	89,806,304	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	503,935	192.00
192.01	19201	RENTED SPACE	0	0	192.01
194.00	07950	FUND DEVELOPMENT	0	17	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-12,532,995	90,310,256	200.00

RECLASSIFICATIONS

Provider CCN: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet A-6

Date/Time Prepared:
2/26/2019 11:50 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - RECLASS CAFETERIA COSTS					
1.00	CAFETERIA	11.00	889,824	932,892	1.00
	O		889,824	932,892	
B - RECLASS SPOILED DRUGS EXPENSE					
1.00	PHARMACY	15.00	0	2,330	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	O		0	2,330	
C - RECLASS CHARGEABLE DRUG COSTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,184,406	1.00
	O		0	4,184,406	
D - RECLASS INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	424,288	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	45,218	2.00
	O		0	469,506	
G - RECLASS REAL ESTATE TAXES					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	153,800	1.00
	O		0	153,800	
H - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,756,694	1.00
	O		0	1,756,694	
500.00	Grand Total: Increases		889,824	7,499,628	500.00

RECLASSIFICATIONS

Provider CCN: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet A-6

Date/Time Prepared:
2/26/2019 11:50 am

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - RECLASS CAFETERIA COSTS						
1.00	DIETARY	10.00	889,824	932,892	0	1.00
	O		889,824	932,892		
B - RECLASS SPOILED DRUGS EXPENSE						
1.00	ADULTS & PEDIATRICS	30.00	0	1,817	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	479	0	2.00
3.00	SKILLED NURSING FACILITY	44.00	0	34	0	3.00
	O		0	2,330		
C - RECLASS CHARGEABLE DRUG COSTS						
1.00	PHARMACY	15.00	0	4,184,406	0	1.00
	O		0	4,184,406		
D - RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	469,506	11	1.00
2.00	O	0.00	0	0	11	2.00
	O		0	469,506		
G - RECLASS REAL ESTATE TAXES						
1.00	OPERATION OF PLANT	7.00	0	153,800	0	1.00
	O		0	153,800		
H - IMPLANTS						
1.00	OPERATING ROOM	50.00	0	1,756,694	0	1.00
	O		0	1,756,694		
500.00	Grand Total: Decreases		889,824	7,499,628		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet A-7
Part I
Date/Time Prepared:
2/26/2019 11:50 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	242,737	0	0	0	1.00
2.00	Land Improvements	3,367,582	829,560	0	829,560	2.00
3.00	Buildings and Fixtures	42,159,496	15,153	0	15,153	3.00
4.00	Building Improvements	5,121,823	0	0	0	4.00
5.00	Fixed Equipment	56,186,464	0	0	0	5.00
6.00	Movable Equipment	45,183,086	4,011,958	0	4,011,958	6.00
7.00	HIT designated Assets	2,041,819	1,783,271	0	1,783,271	7.00
8.00	Subtotal (sum of lines 1-7)	154,303,007	6,639,942	0	6,639,942	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	154,303,007	6,639,942	0	6,639,942	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	242,737	0			1.00
2.00	Land Improvements	4,197,142	0			2.00
3.00	Buildings and Fixtures	42,174,649	0			3.00
4.00	Building Improvements	5,121,823	0			4.00
5.00	Fixed Equipment	56,186,464	0			5.00
6.00	Movable Equipment	49,176,067	0			6.00
7.00	HIT designated Assets	3,749,846	0			7.00
8.00	Subtotal (sum of lines 1-7)	160,848,728	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	160,848,728	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet A-7
Part II
Date/Time Prepared:
2/26/2019 11:50 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	1,677,842	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,701,568	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,379,410	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	1,677,842				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,701,568				2.00
3.00	Total (sum of lines 1-2)	0	4,379,410				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet A-7
Part III
Date/Time Prepared:
2/26/2019 11:50 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	110,860,269	0	110,860,269	0.698387	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	48,932,932	1,055,527	47,877,405	0.301613	0	2.00
3.00	Total (sum of lines 1-2)	159,793,201	1,055,527	158,737,674	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of col.s. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,583,029	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,876,424	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	6,459,453	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of col.s. 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	376,817	0	0	0	2,959,846	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	40,159	0	0	0	3,916,583	2.00
3.00	Total (sum of lines 1-2)	416,976	0	0	0	6,876,429	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet A-8

Date/Time Prepared:
2/26/2019 11:50 am

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
				Cost Center	Line #	
				1.00	2.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-47,471	CAP REL COSTS-BLDG & FIXT	1.00	11 1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-5,059	CAP REL COSTS-MVBLE EQUIP	2.00	11 2.00
3.00	Investment income - other (chapter 2)		0		0.00	0 3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		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	-9,928	NONPATIENT TELEPHONES	5.01	0 7.00
8.00	Television and radio service (chapter 21)	A	-18,694	OPERATION OF PLANT	7.00	0 8.00
9.00	Parking lot (chapter 21)		0		0.00	0 9.00
10.00	Provider-based physician adjustment	A-8-2	-7,232,334			0 10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0 11.00
12.00	Related organization transactions (chapter 10)	A-8-1	905,771			0 12.00
13.00	Laundry and linen service		0		0.00	0 13.00
14.00	Cafeteria-employees and guests	B	-584,682	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	-33,217	DRUGS CHARGED TO PATIENTS	73.00	0 17.00
18.00	Sale of medical records and abstracts	B	-26,189	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	-13,040	DIETARY	10.00	0 20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0 21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0 22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00	24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00	25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0 26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0 27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	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	*** Cost Center Deleted ***	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

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet A-8

Date/Time Prepared:
2/26/2019 11:50 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center	Line #		
			1.00	2.00	3.00	
33.00 MISCELLANEOUS NURSE ADMIN INCOME	B	-835	NURSING ADMINISTRATION	13.00	0	33.00
33.01 MISCELLANEOUS WOC CONTRACTUAL INCOME	B	-8,842	CLINIC	90.00	0	33.01
33.02 TRUST ACCOUNT FEES	A	86,388	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.02
33.03 WEE CARE	B	-728	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.03
33.04 CHILDBIRTH PREP	B	0	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.04
33.05 DOORBELL DINNERS	B	-52,783	DIETARY	10.00	0	33.05
33.06 EDUCATION	B	-15	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.06
33.07 MISCELLANEOUS INCOME	B	-6,936	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.07
33.08 EDUCATION INCOME - AHA	B	-24,248	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.08
33.09 MISCELLANEOUS PT INCOME	B	-74,478	PHYSICAL THERAPY	66.00	0	33.09
33.10 RADIATION THERAPY CABLE EXPENSE	A	-673	RADIOLOGY-DIAGNOSTIC	54.00	0	33.10
33.11 INDUSTRIAL REHAB CABLE EXPENSE	A	-3,946	PHYSICAL THERAPY	66.00	0	33.11
33.12 HYPERBARICS CABLE EXPENSE	A	-1,144	HYPERBARIC OXYGEN THERAPY	76.98	0	33.12
33.13 INTERMEDIARY DEPRECIATION ADJUSTMENT	A	30,552	CAP REL COSTS-BLDG & FIXT	1.00	9	33.13
33.14 SELF INSURANCE	A	-3,869,112	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.14
33.15 PHYSICIAN RECRUITMENT	A	-67,591	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.15
33.16 PARAMEDIC SALARY EXPENSE	A	0	EMERGENCY	91.00	0	33.16
33.17 PARAMEDIC EMPLOYEE BENEFIT EXPENSE	A	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.17
33.18 PARAMEDIC OTHER EXPENSE	A	0	EMERGENCY	91.00	0	33.18
33.19 PARAMEDIC CRC EXPENSE	A	0	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.19
33.20 CRNA SALARIES	A	68,489	NONPHYSICIAN ANESTHETISTS	19.00	0	33.20
33.21 LOBBYING EXPENSE	A	-27,605	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.21
33.22 COMMUNITY RELATIONS SALARY EXPENSE	A	-239,757	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.22
33.23 COMMUNITY RELATIONS BENEFITS EXPENSE	A	-64,351	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.23
33.24 COMMUNITY RELATIONS OTHER EXPENSE	A	-283,941	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.24
33.25 ALCOHOL EXPENSE	A	-1,063	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.25
33.26 LIFE LINE EXPENSES	A	-53,897	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.26
33.27 REVALUED ASSETS DEPRECIATION ADJUSTM	A	849,790	CAP REL COSTS-BLDG & FIXT	1.00	9	33.27
33.28 REVALUED ASSETS DEPRECIATION ADJUSTM	A	1,174,042	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.28
33.30 COMMUNITY BENEFIT SALARY EXPENSE	A	-225,806	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.30
33.31 COMMUNITY BENEFIT BENEFITS EXPENSE	A	-60,606	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.31
33.32 COMMUNITY BENEFIT OTHER EXPENSE	A	-193,698	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.32
33.33 INCOME TAX EXPENSE	A	3,078	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.33
33.34 PROVIDER TAX	A	-2,747,165	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.34
33.35 RETIREE HEALTH INSURANCE PLAN	A	347,505	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.35
33.36 EMPLOYEE SERVICES INCOME	B	-97	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.36
33.37 SURGERY MISCELLANEOUS INCOME	B	31	OPERATING ROOM	50.00	0	33.37
33.38 CENTRAL STERILE MISCELLANEOUS INCOME	B	-100	OPERATING ROOM	50.00	0	33.38
33.39 INTERPRETATION MISCELLANEOUS INCOME	B	-18,610	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.39
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-12,532,995				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet A-8

Date/Time Prepared:
2/26/2019 11:50 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
	1.00	2.00	3.00	4.00	5.00

- 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: 14-0058
 Period: From 10/01/2017 To 09/30/2018
 Worksheet A-8-1
 Date/Time Prepared: 2/26/2019 11:50 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	CAP BLDG HO	24,845	0
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	CAP MME HO MME CAP	814	0
3.00	5.06	OTHER ADMINISTRATIVE AND GEN	HO INTEREST	22,972	0
4.00	5.06	OTHER ADMINISTRATIVE AND GEN	A&G HO MANAGEMENT	2,839,687	1,982,547
4.01	0.00			0	0
4.02	0.00			0	0
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			2,888,318	1,982,547

* 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	0.00	MEMORIAL HL SYS	100.00	6.00
7.00	C	0.00	PPA	100.00	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: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet A-8-1

Date/Time Prepared:
2/26/2019 11:50 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	24,845	9		1.00
2.00	814	9		2.00
3.00	22,972	0		3.00
4.00	857,140	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
5.00	905,771			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	HOME OFFICE		6.00
7.00	PHYSICIAN ORG		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: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet A-8-2

Date/Time Prepared:
2/26/2019 11:50 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	5.06	OTHER ADMINISTRATIVE AND GENERAL	1,838,510	1,766,597	71,913	211,500	340	1.00
2.00	30.00	ADULTS & PEDIATRICS	2,134,735	2,134,735	0	211,500	0	2.00
3.00	40.00	SUBPROVIDER - IPF	182,020	156,257	25,763	181,300	172	3.00
4.00	50.00	OPERATING ROOM	-2,350	-2,350	0	246,400	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	8,410	760	7,650	271,900	38	5.00
6.00	60.00	LABORATORY	75,000	75,000	0	260,300	0	6.00
7.00	65.00	RESPIRATORY THERAPY	-1,685	-4,323	2,638	211,500	11	7.00
8.00	74.00	RENAL DIALYSIS	46,324	46,324	0	211,500	0	8.00
9.00	90.00	CLINIC	1,172,199	1,165,369	6,830	211,500	34	9.00
10.00	91.00	EMERGENCY	1,890,227	1,838,277	51,950	211,500	716	10.00
200.00			7,343,390	7,176,646	166,744		1,311	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	5.06	OTHER ADMINISTRATIVE AND GENERAL	34,572	1,729	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	14,992	750	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	4,967	248	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	1,118	56	0	0	0	7.00
8.00	74.00	RENAL DIALYSIS	0	0	0	0	0	8.00
9.00	90.00	CLINIC	3,457	173	0	0	0	9.00
10.00	91.00	EMERGENCY	72,805	3,640	0	0	0	10.00
200.00			131,911	6,596	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	5.06	OTHER ADMINISTRATIVE AND GENERAL	0	34,572	37,341	1,803,938		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,134,735		2.00
3.00	40.00	SUBPROVIDER - IPF	0	14,992	10,771	167,028		3.00
4.00	50.00	OPERATING ROOM	0	0	0	-2,350		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	4,967	2,683	3,443		5.00
6.00	60.00	LABORATORY	0	0	0	75,000		6.00
7.00	65.00	RESPIRATORY THERAPY	0	1,118	1,520	-2,803		7.00
8.00	74.00	RENAL DIALYSIS	0	0	0	46,324		8.00
9.00	90.00	CLINIC	0	3,457	3,373	1,168,742		9.00
10.00	91.00	EMERGENCY	0	72,805	0	1,838,277		10.00
200.00			0	131,911	55,688	7,232,334		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet B
Part I
Date/Time Prepared:
2/26/2019 11:50 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,959,846	2,959,846			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	3,916,583		3,916,583		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	12,303,567	71,550	44,873	12,419,990	4.00
5.01 00540	NONPATIENT TELEPHONES	53,477	9,019	0		5.01
5.02 00550	DATA PROCESSING	2,940,530	32,291	388,956	270,177	5.02
5.03 00560	PURCHASING RECEIVING AND STORES	513,421	83,469	0	97,152	5.03
5.04 00570	ADMINISTRATIVE	793,594	11,113	662	215,627	5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	1,289,681	21,680	0	199,004	5.05
5.06 00590	OTHER ADMINISTRATIVE AND GENERAL	9,896,888	245,860	67,918	1,480,445	5.06
7.00 00700	OPERATION OF PLANT	3,905,309	367,217	55,352	308,415	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	381,120	60,088	10,051	71,271	8.00
9.00 00900	HOUSEKEEPING	1,271,341	115,956	40,640	305,298	9.00
10.00 01000	DIETARY	868,821	66,173	43,631	139,449	10.00
11.00 01100	CAFETERIA	1,238,034	51,822	0	251,880	11.00
13.00 01300	NURSING ADMINISTRATION	784,363	14,777	4,089	205,098	13.00
15.00 01500	PHARMACY	1,160,834	28,550	5,146	282,128	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	959,419	32,334	8,128	256,314	16.00
17.00 01700	SOCIAL SERVICE	241,055	0	0	60,243	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	4,928,771	317,650	196,442	1,246,515	30.00
31.00 03100	INTENSIVE CARE UNIT	1,559,068	58,911	61,104	398,360	31.00
40.00 04000	SUBPROVIDER - IPF	1,346,550	58,594	36,325	359,493	40.00
43.00 04300	NURSERY	468,040	8,473	0	116,493	43.00
44.00 04400	SKILLED NURSING FACILITY	977,262	73,665	17,284	260,705	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	7,032,251	188,400	818,155	1,161,743	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	117,010	17,394	0	29,123	52.00
53.00 05300	ANESTHESIOLOGY	537,257	11,331	27,407	51,562	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,680,498	142,947	1,329,116	919,746	54.00
60.00 06000	LABORATORY	4,421,905	86,130	143,737	590,329	60.00
65.00 06500	RESPIRATORY THERAPY	1,349,506	41,266	108,270	325,507	65.00
66.00 06600	PHYSICAL THERAPY	4,288,513	219,731	46,114	1,117,193	66.00
68.00 06800	SPEECH PATHOLOGY	227,780	3,413	571	63,431	68.00
70.00 07000	ELECTROENCEPHALOGRAPHY	7,539	0	0	1,704	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	366,107	59,434	106,000	39,027	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	1,756,694	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	4,151,189	2,672	0	0	73.00
74.00 07400	RENAL DIALYSIS	44,068	0	21,805	5,683	74.00
76.00 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.00
76.97 07697	CARDIAC REHABILITATION	154,660	32,367	10,376	34,783	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	108,764	0	0	21,789	76.98
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	844,820	34,286	43,956	315,597	90.00
91.00 09100	EMERGENCY	4,960,169	226,198	160,303	1,128,080	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	89,806,304	2,794,761	3,796,411	12,329,364	62,496
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14,046	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	503,935	1,374	120,172	90,626	192.00
192.01 19201	RENTED SPACE	0	149,665	0	0	192.01
194.00 07950	FUND DEVELOPMENT	17	0	0	0	194.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	TOTAL (sum lines 118 through 201)	90,310,256	2,959,846	3,916,583	12,419,990	62,496

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet B
Part I
Date/Time Prepared:
2/26/2019 11:50 am

Cost Center Description		DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMINITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	
		5.02	5.03	5.04	5.05	5A.05	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550	3,631,954					5.02
5.03	00560	39,042	733,084				5.03
5.04	00570	195,307	17,545	1,233,848			5.04
5.05	00580	234,348	49,648	0	1,794,361		5.05
5.06	00590	585,820	98,143	0	0	12,375,074	5.06
7.00	00700	0	72,959	0	0	4,709,252	7.00
8.00	00800	0	73,468	0	0	595,998	8.00
9.00	00900	0	69,079	0	0	1,802,314	9.00
10.00	01000	117,125	47,537	0	0	1,282,736	10.00
11.00	01100	0	80,930	0	0	1,622,666	11.00
13.00	01300	390,515	1,830	0	0	1,400,672	13.00
15.00	01500	78,083	11,904	0	0	1,566,645	15.00
16.00	01600	156,166	0	0	0	1,412,361	16.00
17.00	01700	39,042	8,234	0	0	348,574	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	78,083	15,537	65,310	94,983	6,974,539	30.00
31.00	03100	234,348	4,061	20,406	29,677	2,365,935	31.00
40.00	04000	195,307	8,585	10,712	15,579	2,031,145	40.00
43.00	04300	0	851	4,549	6,617	629,327	43.00
44.00	04400	78,083	4,300	18,435	26,811	1,456,545	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	39,042	56,793	167,165	243,116	9,706,665	50.00
52.00	05200	0	213	4,661	6,778	182,123	52.00
53.00	05300	0	1,886	25,058	36,443	690,944	53.00
54.00	05400	195,307	12,110	382,487	556,188	8,218,399	54.00
60.00	06000	195,307	49,716	143,022	208,004	5,838,150	60.00
65.00	06500	117,125	25,645	71,381	103,812	2,142,512	65.00
66.00	06600	312,431	10,208	88,754	129,079	6,212,023	66.00
68.00	06800	0	47	4,360	6,341	305,943	68.00
70.00	07000	0	478	323	470	10,514	70.00
71.00	07100	0	3,218	20,835	30,302	624,923	71.00
72.00	07200	0	0	18,417	26,785	1,801,896	72.00
73.00	07300	0	0	80,913	117,675	4,352,449	73.00
74.00	07400	0	0	2,115	3,075	76,746	74.00
76.00	03950	0	0	0	0	0	76.00
76.97	07697	0	693	2,047	2,977	237,903	76.97
76.98	07698	0	236	3,960	5,759	140,508	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	5,276	10,775	15,670	1,270,380	90.00
91.00	09100	312,431	0	88,163	128,220	7,003,564	91.00
92.00	09200					0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		3,592,912	731,130	1,233,848	1,794,361	89,389,425	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	14,046	190.00
192.00	19200	39,042	1,954	0	0	757,103	192.00
192.01	19201	0	0	0	0	149,665	192.01
194.00	07950	0	0	0	0	17	194.00
200.00						0	200.00
201.00		0	0	0	0	0	201.00
202.00		3,631,954	733,084	1,233,848	1,794,361	90,310,256	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet B
Part I
Date/Time Prepared:
2/26/2019 11:50 am

Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.06	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
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMINITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	12,375,074				5.06
7.00	00700	OPERATION OF PLANT	747,768	5,457,020			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	94,637	154,843	845,478		8.00
9.00	00900	HOUSEKEEPING	286,184	298,810	0	2,387,308	9.00
10.00	01000	DIETARY	203,682	170,524	0	4,777	1,661,719
11.00	01100	CAFETERIA	257,658	133,542	0	0	0
13.00	01300	NURSING ADMINISTRATION	222,409	38,078	0	77,534	0
15.00	01500	PHARMACY	248,763	73,571	0	7,603	0
16.00	01600	MEDICAL RECORDS & LIBRARY	224,265	83,323	0	3,437	0
17.00	01700	SOCIAL SERVICE	55,349	0	0	854	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,107,466	818,561	422,739	1,013,790	938,692
31.00	03100	INTENSIVE CARE UNIT	375,680	151,808	0	9,714	75,032
40.00	04000	SUBPROVIDER - IPF	322,519	150,993	0	0	240,395
43.00	04300	NURSERY	99,929	21,835	338,183	811,029	0
44.00	04400	SKILLED NURSING FACILITY	231,280	189,830	0	17,741	407,600
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,541,272	485,493	0	32,774	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	28,919	44,823	84,556	202,757	0
53.00	05300	ANESTHESIOLOGY	109,713	29,198	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,304,975	368,363	0	15,554	0
60.00	06000	LABORATORY	927,022	221,951	0	11,214	0
65.00	06500	RESPIRATORY THERAPY	340,203	106,339	0	9,950	0
66.00	06600	PHYSICAL THERAPY	986,388	566,231	0	31,080	0
68.00	06800	SPEECH PATHOLOGY	48,580	8,796	0	5,416	0
70.00	07000	ELECTROENCEPHALOGRAPHY	1,669	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	99,230	153,157	0	5,798	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	286,118	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	691,112	6,885	0	0	0
74.00	07400	RENAL DIALYSIS	12,186	0	0	0	0
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	37,776	83,407	0	3,819	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	22,311	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	201,720	88,353	0	0	0
91.00	09100	EMERGENCY	1,112,075	582,895	0	68,771	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,228,858	5,031,609	845,478	2,333,612	1,661,719
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,230	36,196	0	10,138	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	120,218	3,541	0	43,558	0
192.01	19201	RENTED SPACE	23,765	385,674	0	0	0
194.00	07950	FUND DEVELOPMENT	3	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)	12,375,074	5,457,020	845,478	2,387,308	1,661,719

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet B
Part I
Date/Time Prepared:
2/26/2019 11:50 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		11.00	13.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00590						5.06
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	2,013,866					11.00
13.00	01300	32,997	1,771,690				13.00
15.00	01500	40,611	0	1,937,193			15.00
16.00	01600	89,619	0	0	1,813,005		16.00
17.00	01700	12,663	12,129	0	0	429,569	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	348,293	333,435	0	95,970	221,669	30.00
31.00	03100	90,567	86,709	0	29,986	28,991	31.00
40.00	04000	99,130	94,903	0	15,741	55,499	40.00
43.00	04300	28,088	26,887	0	6,685	18,453	43.00
44.00	04400	73,664	70,520	0	27,090	104,957	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	246,849	236,325	25,100	245,643	0	50.00
52.00	05200	7,029	6,722	0	6,849	0	52.00
53.00	05300	6,164	5,900	55,507	36,821	0	53.00
54.00	05400	180,018	172,347	51,943	561,964	0	54.00
60.00	06000	157,118	150,417	846	210,166	0	60.00
65.00	06500	84,040	80,454	12,474	104,891	0	65.00
66.00	06600	164,761	157,730	0	130,420	0	66.00
68.00	06800	6,527	6,242	0	6,407	0	68.00
70.00	07000	279	276	0	475	0	70.00
71.00	07100	15,620	14,951	10,967	30,617	0	71.00
72.00	07200	0	0	0	27,063	0	72.00
73.00	07300	0	0	1,775,798	118,898	0	73.00
74.00	07400	502	492	0	3,107	0	74.00
76.00	03950	0	0	0	0	0	76.00
76.97	07697	5,495	5,247	0	3,008	0	76.97
76.98	07698	4,658	4,459	4	5,819	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	33,499	32,057	1,027	15,833	0	90.00
91.00	09100	273,653	261,991	3,527	129,552	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		2,001,844	1,760,193	1,937,193	1,813,005	429,569	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	12,022	11,497	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		2,013,866	1,771,690	1,937,193	1,813,005	429,569	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet B
Part I
Date/Time Prepared:
2/26/2019 11:50 am

Cost Center Description		NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		19.00	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
5.01	00540	NONPATIENT TELEPHONES				5.01
5.02	00550	DATA PROCESSING				5.02
5.03	00560	PURCHASING RECEIVING AND STORES				5.03
5.04	00570	ADMITTING				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL				5.06
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
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0			19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	12,275,154	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,214,422	0	31.00
40.00	04000	SUBPROVIDER - I/PF	0	3,010,325	0	40.00
43.00	04300	NURSERY	0	1,980,416	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	2,579,227	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	12,520,121	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	563,778	0	52.00
53.00	05300	ANESTHESIOLOGY	0	934,247	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,873,563	0	54.00
60.00	06000	LABORATORY	0	7,516,884	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,880,863	0	65.00
66.00	06600	PHYSICAL THERAPY	0	8,248,633	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	387,911	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	13,213	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	955,263	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,115,077	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,945,142	0	73.00
74.00	07400	RENAL DIALYSIS	0	93,033	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	376,655	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	177,759	0	76.98
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,642,869	0	90.00
91.00	09100	EMERGENCY	0	9,436,028	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	88,740,583	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	62,610	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	947,939	0	192.00
192.01	19201	RENTED SPACE	0	559,104	0	192.01
194.00	07950	FUND DEVELOPMENT	0	20	0	194.00
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	90,310,256	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet B
Part II
Date/Time Prepared:
2/26/2019 11:50 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	71,550	44,873	116,423	4.00
5.01 00540	NONPATIENT TELEPHONES	0	9,019	0	9,019	5.01
5.02 00550	DATA PROCESSING	277	32,291	388,956	421,524	5.02
5.03 00560	PURCHASING RECEIVING AND STORES	0	83,469	0	83,469	5.03
5.04 00570	ADMINITTING	0	11,113	662	11,775	5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	4,320	21,680	0	26,000	5.05
5.06 00590	OTHER ADMINISTRATIVE AND GENERAL	0	245,860	67,918	313,778	5.06
7.00 00700	OPERATION OF PLANT	7,401	367,217	55,352	429,970	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	60,088	10,051	70,139	8.00
9.00 00900	HOUSEKEEPING	0	115,956	40,640	156,596	9.00
10.00 01000	DIETARY	0	66,173	43,631	109,804	10.00
11.00 01100	CAFETERIA	0	51,822	0	51,822	11.00
13.00 01300	NURSING ADMINISTRATION	0	14,777	4,089	18,866	13.00
15.00 01500	PHARMACY	3,900	28,550	5,146	37,596	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	32,334	8,128	40,462	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	29,349	317,650	196,442	543,441	30.00
31.00 03100	INTENSIVE CARE UNIT	17,675	58,911	61,104	137,690	31.00
40.00 04000	SUBPROVIDER - I/PF	0	58,594	36,325	94,919	40.00
43.00 04300	NURSERY	0	8,473	0	8,473	43.00
44.00 04400	SKILLED NURSING FACILITY	8,556	73,665	17,284	99,505	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	44,355	188,400	818,155	1,050,910	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	17,394	0	17,394	52.00
53.00 05300	ANESTHESIOLOGY	13,377	11,331	27,407	52,115	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	142,947	1,329,116	1,472,063	54.00
60.00 06000	LABORATORY	326	86,130	143,737	230,193	60.00
65.00 06500	RESPIRATORY THERAPY	2,874	41,266	108,270	152,410	65.00
66.00 06600	PHYSICAL THERAPY	0	219,731	46,114	265,845	66.00
68.00 06800	SPEECH PATHOLOGY	0	3,413	571	3,984	68.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	59,434	106,000	165,434	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	2,672	0	2,672	73.00
74.00 07400	RENAL DIALYSIS	0	0	21,805	21,805	74.00
76.00 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.00
76.97 07697	CARDIAC REHABILITATION	326	32,367	10,376	43,069	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	34,286	43,956	78,242	90.00
91.00 09100	EMERGENCY	16,926	226,198	160,303	403,427	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	149,662	2,794,761	3,796,411	6,740,834	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14,046	0	14,046	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	7,700	1,374	120,172	129,246	192.00
192.01 19201	RENTED SPACE	0	149,665	0	149,665	192.01
194.00 07950	FUND DEVELOPMENT	0	0	0	0	194.00
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	157,362	2,959,846	3,916,583	7,033,791	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0058		Period: From 10/01/2017 To 09/30/2018		Worksheet B Part II Date/Time Prepared: 2/26/2019 11:50 am	
Cost Center Description			NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMINISTRATIVE	CASHIERING/ACCOUNTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	9,019					5.01
5.02	00550	DATA PROCESSING	0	424,056				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	4,558	88,938			5.03
5.04	00570	ADMINISTRATIVE	0	22,803	2,129	38,728		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	27,362	6,023	0	61,250	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	0	68,401	11,907	0	0	5.06
7.00	00700	OPERATION OF PLANT	0	0	8,851	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	8,913	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	8,381	0	0	9.00
10.00	01000	DIETARY	0	13,675	5,767	0	0	10.00
11.00	01100	CAFETERIA	0	0	9,818	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	45,595	222	0	0	13.00
15.00	01500	PHARMACY	0	9,117	1,444	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	18,233	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	4,558	999	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,510	9,117	1,885	2,056	3,249	30.00
31.00	03100	INTENSIVE CARE UNIT	0	27,362	493	643	1,015	31.00
40.00	04000	SUBPROVIDER - IPF	0	22,803	1,042	337	533	40.00
43.00	04300	NURSERY	3,507	0	103	143	226	43.00
44.00	04400	SKILLED NURSING FACILITY	0	9,117	522	580	917	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	4,558	6,890	5,263	8,316	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,002	0	26	147	232	52.00
53.00	05300	ANESTHESIOLOGY	0	0	229	789	1,247	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,803	1,469	11,922	18,897	54.00
60.00	06000	LABORATORY	0	22,803	6,032	4,503	7,115	60.00
65.00	06500	RESPIRATORY THERAPY	0	13,675	3,111	2,248	3,551	65.00
66.00	06600	PHYSICAL THERAPY	0	36,479	1,238	2,795	4,415	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	6	137	217	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	58	10	16	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	390	656	1,037	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	580	916	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,548	4,025	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	67	105	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	84	64	102	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	29	125	197	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	640	339	536	90.00
91.00	09100	EMERGENCY	0	36,479	0	2,776	4,386	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,019	419,498	88,701	38,728	61,250	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,558	237	0	0	192.00
192.01	19201	RENTED SPACE	0	0	0	0	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	9,019	424,056	88,938	38,728	61,250	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0058		Period: From 10/01/2017 To 09/30/2018		Worksheet B Part II Date/Time Prepared: 2/26/2019 11:50 am	
Cost Center Description			OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMINISTRATIVE						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	407,980					5.06
7.00	00700	OPERATION OF PLANT	24,653	466,365				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,120	13,233	96,073			8.00
9.00	00900	HOUSEKEEPING	9,435	25,537	0	202,810		9.00
10.00	01000	DIETARY	6,715	14,573	0	406	152,247	10.00
11.00	01100	CAFETERIA	8,495	11,413	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	7,333	3,254	0	6,587	0	13.00
15.00	01500	PHARMACY	8,201	6,288	0	646	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,394	7,121	0	292	0	16.00
17.00	01700	SOCIAL SERVICE	1,825	0	0	73	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	36,512	69,955	48,037	86,126	86,004	30.00
31.00	03100	INTENSIVE CARE UNIT	12,386	12,974	0	825	6,874	31.00
40.00	04000	SUBPROVIDER - IPF	10,633	12,904	0	0	22,025	40.00
43.00	04300	NURSERY	3,295	1,866	38,428	68,900	0	43.00
44.00	04400	SKILLED NURSING FACILITY	7,625	16,223	0	1,507	37,344	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	50,803	41,491	0	2,784	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	953	3,831	9,608	17,225	0	52.00
53.00	05300	ANESTHESIOLOGY	3,617	2,495	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	43,023	31,481	0	1,321	0	54.00
60.00	06000	LABORATORY	30,563	18,968	0	953	0	60.00
65.00	06500	RESPIRATORY THERAPY	11,216	9,088	0	845	0	65.00
66.00	06600	PHYSICAL THERAPY	32,520	48,391	0	2,640	0	66.00
68.00	06800	SPEECH PATHOLOGY	1,602	752	0	460	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	55	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,271	13,089	0	493	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,433	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,785	588	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	402	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,245	7,128	0	324	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	736	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	6,650	7,551	0	0	0	90.00
91.00	09100	EMERGENCY	36,664	49,815	0	5,842	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	403,160	430,009	96,073	198,249	152,247	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	74	3,093	0	861	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,963	303	0	3,700	0	192.00
192.01	19201	RENTED SPACE	783	32,960	0	0	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	407,980	466,365	96,073	202,810	152,247	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0058		Period: From 10/01/2017 To 09/30/2018		Worksheet B Part II Date/Time Prepared: 2/26/2019 11:50 am	
Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			11.00	13.00	15.00	16.00	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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMINITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
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	83,909					11.00
13.00	01300	NURSING ADMINISTRATION	1,375	85,154				13.00
15.00	01500	PHARMACY	1,692	0	67,628			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,734	0	0	79,638		16.00
17.00	01700	SOCIAL SERVICE	528	583	0	0	9,131	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,510	16,025	0	4,216	4,712	30.00
31.00	03100	INTENSIVE CARE UNIT	3,774	4,168	0	1,317	616	31.00
40.00	04000	SUBPROVIDER - IPF	4,130	4,561	0	691	1,180	40.00
43.00	04300	NURSERY	1,170	1,292	0	294	392	43.00
44.00	04400	SKILLED NURSING FACILITY	3,069	3,389	0	1,190	2,231	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,285	11,359	876	10,790	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	293	323	0	301	0	52.00
53.00	05300	ANESTHESIOLOGY	257	284	1,938	1,617	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,501	8,284	1,813	24,685	0	54.00
60.00	06000	LABORATORY	6,546	7,230	30	9,232	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,502	3,867	435	4,607	0	65.00
66.00	06600	PHYSICAL THERAPY	6,865	7,581	0	5,729	0	66.00
68.00	06800	SPEECH PATHOLOGY	272	300	0	281	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	12	13	0	21	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	651	719	383	1,345	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,189	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	61,994	5,223	0	73.00
74.00	07400	RENAL DIALYSIS	21	24	0	136	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	229	252	0	132	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	194	214	0	256	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,396	1,541	36	695	0	90.00
91.00	09100	EMERGENCY	11,402	12,592	123	5,691	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	83,408	84,601	67,628	79,638	9,131	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	501	553	0	0	0	192.00
192.01	19201	RENTED SPACE	0	0	0	0	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	83,909	85,154	67,628	79,638	9,131	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet B
Part II
Date/Time Prepared:
2/26/2019 11:50 am

Cost Center Description		NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		19.00	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
5.01	00540	NONPATIENT TELEPHONES				5.01
5.02	00550	DATA PROCESSING				5.02
5.03	00560	PURCHASING RECEIVING AND STORES				5.03
5.04	00570	ADMITTING				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL				5.06
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
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0			19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	942,038	0	942,038	30.00
31.00	03100	INTENSIVE CARE UNIT	213,871	0	213,871	31.00
40.00	04000	SUBPROVIDER - IPF	179,127	0	179,127	40.00
43.00	04300	NURSERY	129,181	0	129,181	43.00
44.00	04400	SKILLED NURSING FACILITY	185,662	0	185,662	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,215,213	0	1,215,213	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	51,608	0	51,608	52.00
53.00	05300	ANESTHESIOLOGY	65,071	0	65,071	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,653,882	0	1,653,882	54.00
60.00	06000	LABORATORY	349,701	0	349,701	60.00
65.00	06500	RESPIRATORY THERAPY	211,606	0	211,606	65.00
66.00	06600	PHYSICAL THERAPY	424,969	0	424,969	66.00
68.00	06800	SPEECH PATHOLOGY	8,605	0	8,605	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	201	0	201	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	187,834	0	187,834	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,118	0	12,118	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	99,835	0	99,835	73.00
74.00	07400	RENAL DIALYSIS	22,613	0	22,613	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	52,955	0	52,955	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,955	0	1,955	76.98
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	100,584	0	100,584	90.00
91.00	09100	EMERGENCY	579,770	0	579,770	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	6,688,399	0	6,688,399
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	18,074	0	18,074	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	143,910	0	143,910	192.00
192.01	19201	RENTED SPACE	183,408	0	183,408	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	194.00
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	7,033,791	0	7,033,791

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet B-1
Date/Time Prepared:
2/26/2019 11:50 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF PHONES)	DATA PROCESSING (DEPT TIME)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	271,413				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		3,447,816			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	6,561	39,502	43,876,523		4.00
5.01 00540	NONPATIENT TELEPHONES	827	0	0	18	5.01
5.02 00550	DATA PROCESSING	2,961	342,403	954,464	0	36,560 5.02
5.03 00560	PURCHASING RECEIVING AND STORES	7,654	0	343,211	0	393 5.03
5.04 00570	ADMINISTRATIVE	1,019	583	761,754	0	1,966 5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	1,988	0	703,028	0	2,359 5.05
5.06 00590	OTHER ADMINISTRATIVE AND GENERAL	22,545	59,789	5,230,033	0	5,897 5.06
7.00 00700	OPERATION OF PLANT	33,673	48,727	1,089,547	0	0 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	5,510	8,848	251,783	0	0 8.00
9.00 00900	HOUSEKEEPING	10,633	35,776	1,078,536	0	0 9.00
10.00 01000	DIETARY	6,068	38,409	492,636	0	1,179 10.00
11.00 01100	CAFETERIA	4,752	0	889,824	0	0 11.00
13.00 01300	NURSING ADMINISTRATION	1,355	3,600	724,558	0	3,931 13.00
15.00 01500	PHARMACY	2,618	4,530	996,682	0	786 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,965	7,155	905,489	0	1,572 16.00
17.00 01700	SOCIAL SERVICE	0	0	212,823	0	393 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	29,128	172,930	4,403,603	9	786 30.00
31.00 03100	INTENSIVE CARE UNIT	5,402	53,791	1,407,300	0	2,359 31.00
40.00 04000	SUBPROVIDER - I/P	5,373	31,977	1,269,994	0	1,966 40.00
43.00 04300	NURSERY	777	0	411,539	7	0 43.00
44.00 04400	SKILLED NURSING FACILITY	6,755	15,215	921,002	0	786 44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	17,276	720,232	4,104,128	0	393 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,595	0	102,885	2	0 52.00
53.00 05300	ANESTHESIOLOGY	1,039	24,127	182,154	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	13,108	1,170,037	3,249,215	0	1,966 54.00
60.00 06000	LABORATORY	7,898	126,533	2,085,474	0	1,966 60.00
65.00 06500	RESPIRATORY THERAPY	3,784	95,311	1,149,928	0	1,179 65.00
66.00 06600	PHYSICAL THERAPY	20,149	40,595	3,946,743	0	3,145 66.00
68.00 06800	SPEECH PATHOLOGY	313	503	224,085	0	0 68.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	6,020	0	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,450	93,313	137,872	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	245	0	0	0	0 73.00
74.00 07400	RENAL DIALYSIS	0	19,195	20,077	0	0 74.00
76.00 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0 76.00
76.97 07697	CARDIAC REHABILITATION	2,968	9,134	122,879	0	0 76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	76,973	0	0 76.98
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	3,144	38,695	1,114,919	0	0 90.00
91.00 09100	EMERGENCY	20,742	141,117	3,985,206	0	3,145 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	256,275	3,342,027	43,556,364	18	36,167 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,288	0	0	0	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	126	105,789	320,159	0	393 192.00
192.01 19201	RENTED SPACE	13,724	0	0	0	0 192.01
194.00 07950	FUND DEVELOPMENT	0	0	0	0	0 194.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,959,846	3,916,583	12,419,990	62,496	3,631,954 202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	10.905321	1.135961	0.283067	3,472.000000	99.342287 203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			116,423	9,019	424,056 204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.002653	501.055556	11.598906 205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet B-1
Date/Time Prepared:
2/26/2019 11:50 am

Cost Center Description		PURCHASING RECEIVING AND STORES (COST OF SUPPLIES)	ADMINITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
		5.03	5.04	5.05	5A.06	5.06	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560	1,114,162					5.03
5.04	00570	26,665	388,466,950				5.04
5.05	00580	75,457	0	388,466,950			5.05
5.06	00590	149,161	0	0	-12,375,074	77,935,182	5.06
7.00	00700	110,885	0	0	0	4,709,252	7.00
8.00	00800	111,658	0	0	0	595,998	8.00
9.00	00900	104,988	0	0	0	1,802,314	9.00
10.00	01000	72,248	0	0	0	1,282,736	10.00
11.00	01100	122,999	0	0	0	1,622,666	11.00
13.00	01300	2,782	0	0	0	1,400,672	13.00
15.00	01500	18,092	0	0	0	1,566,645	15.00
16.00	01600	0	0	0	0	1,412,361	16.00
17.00	01700	12,514	0	0	0	348,574	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	23,613	20,563,638	20,563,638	0	6,974,539	30.00
31.00	03100	6,172	6,425,080	6,425,080	0	2,365,935	31.00
40.00	04000	13,048	3,372,911	3,372,911	0	2,031,145	40.00
43.00	04300	1,294	1,432,458	1,432,458	0	629,327	43.00
44.00	04400	6,535	5,804,598	5,804,598	0	1,456,545	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	86,315	52,633,969	52,633,969	0	9,706,665	50.00
52.00	05200	324	1,467,494	1,467,494	0	182,123	52.00
53.00	05300	2,867	7,889,711	7,889,711	0	690,944	53.00
54.00	05400	18,405	120,405,492	120,405,492	0	8,218,399	54.00
60.00	06000	75,560	45,032,261	45,032,261	0	5,838,150	60.00
65.00	06500	38,976	22,475,065	22,475,065	0	2,142,512	65.00
66.00	06600	15,514	27,945,172	27,945,172	0	6,212,023	66.00
68.00	06800	71	1,372,901	1,372,901	0	305,943	68.00
70.00	07000	727	101,835	101,835	0	10,514	70.00
71.00	07100	4,891	6,560,275	6,560,275	0	624,923	71.00
72.00	07200	0	5,798,892	5,798,892	0	1,801,896	72.00
73.00	07300	0	25,476,397	25,476,397	0	4,352,449	73.00
74.00	07400	0	665,823	665,823	0	76,746	74.00
76.00	03950	0	0	0	0	0	76.00
76.97	07697	1,054	644,452	644,452	0	237,903	76.97
76.98	07698	358	1,246,849	1,246,849	0	140,508	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	8,019	3,392,480	3,392,480	0	1,270,380	90.00
91.00	09100	0	27,759,197	27,759,197	0	7,003,564	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		1,111,192	388,466,950	388,466,950	-12,375,074	77,014,351	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	14,046	190.00
192.00	19200	2,970	0	0	0	757,103	192.00
192.01	19201	0	0	0	0	149,665	192.01
194.00	07950	0	0	0	0	17	194.00
200.00							200.00
201.00							201.00
202.00		733,084	1,233,848	1,794,361		12,375,074	202.00
203.00		0.657969	0.003176	0.004619		0.158787	203.00
204.00		88,938	38,728	61,250		407,980	204.00
205.00		0.079825	0.000100	0.000158		0.005235	205.00
206.00							206.00
207.00							207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet B-1
Date/Time Prepared:
2/26/2019 11:50 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMINISTRATIVE					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL					5.06
7.00	00700	OPERATION OF PLANT	194,185				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,510	20,788			8.00
9.00	00900	HOUSEKEEPING	10,633	0	343,807		9.00
10.00	01000	DIETARY	6,068	0	688	53,219	10.00
11.00	01100	CAFETERIA	4,752	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,355	0	11,166	0	1,183
15.00	01500	PHARMACY	2,618	0	1,095	0	1,456
16.00	01600	MEDICAL RECORDS & LIBRARY	2,965	0	495	0	3,213
17.00	01700	SOCIAL SERVICE	0	0	123	0	454
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	29,128	10,394	146,000	30,063	12,487
31.00	03100	INTENSIVE CARE UNIT	5,402	0	1,399	2,403	3,247
40.00	04000	SUBPROVIDER - IPF	5,373	0	0	7,699	3,554
43.00	04300	NURSERY	777	8,315	116,800	0	1,007
44.00	04400	SKILLED NURSING FACILITY	6,755	0	2,555	13,054	2,641
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	17,276	0	4,720	0	8,850
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,595	2,079	29,200	0	252
53.00	05300	ANESTHESIOLOGY	1,039	0	0	0	221
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,108	0	2,240	13,000	6,454
60.00	06000	LABORATORY	7,898	0	1,615	0	5,633
65.00	06500	RESPIRATORY THERAPY	3,784	0	1,433	0	3,013
66.00	06600	PHYSICAL THERAPY	20,149	0	4,476	0	5,907
68.00	06800	SPEECH PATHOLOGY	313	0	780	0	234
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,450	0	835	0	560
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	245	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	18
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	2,968	0	550	0	197
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	167
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	3,144	0	0	0	1,201
91.00	09100	EMERGENCY	20,742	0	9,904	0	9,811
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	179,047	20,788	336,074	53,219	71,770
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,288	0	1,460	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	126	0	6,273	0	431
192.01	19201	RENTED SPACE	13,724	0	0	0	0
194.00	07950	FUND DEVELOPMENT	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)	5,457,020	845,478	2,387,308	1,661,719	2,013,866
203.00		Unit cost multiplier (Wkst. B, Part I)	28.102171	40.671445	6.943745	31.224168	27.892495
204.00		Cost to be allocated (per Wkst. B, Part II)	466,365	96,073	202,810	152,247	83,909
205.00		Unit cost multiplier (Wkst. B, Part II)	2.401653	4.621561	0.589895	2.860764	1.162158
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: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet B-1
Date/Time Prepared:
2/26/2019 11:50 am

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURS. HRS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		13.00	15.00	16.00	17.00	19.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00590						5.06
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	1,380,064					13.00
15.00	01500	0	4,564,555				15.00
16.00	01600	0	0	388,466,950			16.00
17.00	01700	9,448	0	0	18,344		17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	259,731	0	20,563,638	9,466	0	30.00
31.00	03100	67,542	0	6,425,080	1,238	0	31.00
40.00	04000	73,925	0	3,372,911	2,370	0	40.00
43.00	04300	20,944	0	1,432,458	788	0	43.00
44.00	04400	54,932	0	5,804,598	4,482	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	184,086	59,142	52,633,969	0	0	50.00
52.00	05200	5,236	0	1,467,494	0	0	52.00
53.00	05300	4,596	130,789	7,889,711	0	0	53.00
54.00	05400	134,250	122,391	120,405,492	0	0	54.00
60.00	06000	117,168	1,994	45,032,261	0	0	60.00
65.00	06500	62,670	29,392	22,475,065	0	0	65.00
66.00	06600	122,864	0	27,945,172	0	0	66.00
68.00	06800	4,862	0	1,372,901	0	0	68.00
70.00	07000	215	0	101,835	0	0	70.00
71.00	07100	11,646	25,842	6,560,275	0	0	71.00
72.00	07200	0	0	5,798,892	0	0	72.00
73.00	07300	0	4,184,266	25,476,397	0	0	73.00
74.00	07400	383	0	665,823	0	0	74.00
76.00	03950	0	0	0	0	0	76.00
76.97	07697	4,087	0	644,452	0	0	76.97
76.98	07698	3,473	9	1,246,849	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	24,971	2,420	3,392,480	0	0	90.00
91.00	09100	204,079	8,310	27,759,197	0	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		1,371,108	4,564,555	388,466,950	18,344	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	8,956	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00							201.00
202.00		1,771,690	1,937,193	1,813,005	429,569	0	202.00
203.00		1.283774	0.424399	0.004667	23.417412	0.000000	203.00
204.00		85,154	67,628	79,638	9,131	0	204.00
205.00		0.061703	0.014816	0.000205	0.497765	0.000000	205.00
206.00							206.00
207.00							207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet C
Part I
Date/Time Prepared:
2/26/2019 11:50 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	Hospital		
					RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	12,275,154		12,275,154	0	12,275,154	30.00
31.00	03100 INTENSIVE CARE UNIT	3,214,422		3,214,422	0	3,214,422	31.00
40.00	04000 SUBPROVIDER - IPF	3,010,325		3,010,325	10,771	3,021,096	40.00
43.00	04300 NURSERY	1,980,416		1,980,416	0	1,980,416	43.00
44.00	04400 SKILLED NURSING FACILITY	2,579,227		2,579,227	0	2,579,227	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	12,520,121		12,520,121	0	12,520,121	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	563,778		563,778	0	563,778	52.00
53.00	05300 ANESTHESIOLOGY	934,247		934,247	0	934,247	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	10,873,563		10,873,563	2,683	10,876,246	54.00
60.00	06000 LABORATORY	7,516,884		7,516,884	0	7,516,884	60.00
65.00	06500 RESPIRATORY THERAPY	2,880,863	0	2,880,863	1,520	2,882,383	65.00
66.00	06600 PHYSICAL THERAPY	8,248,633	0	8,248,633	0	8,248,633	66.00
68.00	06800 SPEECH PATHOLOGY	387,911	0	387,911	0	387,911	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	13,213		13,213	0	13,213	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	955,263		955,263	0	955,263	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2,115,077		2,115,077	0	2,115,077	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	6,945,142		6,945,142	0	6,945,142	73.00
74.00	07400 RENAL DIALYSIS	93,033		93,033	0	93,033	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	376,655		376,655	0	376,655	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	177,759		177,759	0	177,759	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	1,642,869		1,642,869	3,373	1,646,242	90.00
91.00	09100 EMERGENCY	9,436,028		9,436,028	0	9,436,028	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	654,332		654,332		654,332	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	89,394,915	0	89,394,915	18,347	89,413,262	200.00
201.00	Less Observation Beds	654,332		654,332		654,332	201.00
202.00	Total (see instructions)	88,740,583	0	88,740,583	18,347	88,758,930	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0058	Period: From 10/01/2017 To 09/30/2018	Worksheet C Part I Date/Time Prepared: 2/26/2019 11:50 am
		Title XVIII	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
9.00	10.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,762,302		19,762,302	30.00
31.00	03100	INTENSIVE CARE UNIT	6,425,080		6,425,080	31.00
40.00	04000	SUBPROVIDER - IPF	3,372,911		3,372,911	40.00
43.00	04300	NURSERY	1,432,458		1,432,458	43.00
44.00	04400	SKILLED NURSING FACILITY	5,804,598		5,804,598	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,233,837	38,400,132	52,633,969	0.237871 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,076,514	390,980	1,467,494	0.384177 52.00
53.00	05300	ANESTHESIOLOGY	2,115,110	5,774,601	7,889,711	0.118413 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,399,317	111,006,175	120,405,492	0.090308 54.00
60.00	06000	LABORATORY	15,835,224	29,197,037	45,032,261	0.166922 60.00
65.00	06500	RESPIRATORY THERAPY	10,186,337	12,288,728	22,475,065	0.128180 65.00
66.00	06600	PHYSICAL THERAPY	5,547,747	22,397,425	27,945,172	0.295172 66.00
68.00	06800	SPEECH PATHOLOGY	321,904	1,050,997	1,372,901	0.282548 68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	9,893	91,942	101,835	0.129749 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,910,596	2,649,679	6,560,275	0.145613 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,540,340	2,258,552	5,798,892	0.364738 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,856,597	13,619,800	25,476,397	0.272611 73.00
74.00	07400	RENAL DIALYSIS	665,823	0	665,823	0.139726 74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000 76.00
76.97	07697	CARDIAC REHABILITATION	789	643,663	644,452	0.584458 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	566	1,246,283	1,246,849	0.142567 76.98
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	75,932	3,316,548	3,392,480	0.484268 90.00
91.00	09100	EMERGENCY	4,752,184	23,007,013	27,759,197	0.339924 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	168,092	633,244	801,336	0.816551 92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)	120,494,151	267,972,799	388,466,950	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	120,494,151	267,972,799	388,466,950	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0058	Period: From 10/01/2017 To 09/30/2018	Worksheet C Part I Date/Time Prepared: 2/26/2019 11:50 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
40.00	04000 SUBPROVIDER - IPF			40.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.237871		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.384177		52.00
53.00	05300 ANESTHESIOLOGY	0.118413		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.090330		54.00
60.00	06000 LABORATORY	0.166922		60.00
65.00	06500 RESPIRATORY THERAPY	0.128248		65.00
66.00	06600 PHYSICAL THERAPY	0.295172		66.00
68.00	06800 SPEECH PATHOLOGY	0.282548		68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.129749		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.145613		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.364738		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.272611		73.00
74.00	07400 RENAL DIALYSIS	0.139726		74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.00
76.97	07697 CARDIAC REHABILITATION	0.584458		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.142567		76.98
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.485262		90.00
91.00	09100 EMERGENCY	0.339924		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.816551		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-0058	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part I Date/Time Prepared: 2/26/2019 11:50 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)	
		1.00	2.00	3.00	4.00	5.00	
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	942,038	0	942,038	9,999	94.21	30.00
31.00	INTENSIVE CARE UNIT	213,871	0	213,871	1,238	172.76	31.00
40.00	SUBPROVIDER - IPF	179,127	0	179,127	2,370	75.58	40.00
43.00	NURSERY	129,181		129,181	788	163.94	43.00
44.00	SKILLED NURSING FACILITY	185,662		185,662	4,482	41.42	44.00
200.00	Total (lines 30 through 199)	1,649,879		1,649,879	18,877		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	5,048	475,572				
31.00	INTENSIVE CARE UNIT	668	115,404				
40.00	SUBPROVIDER - IPF	345	26,075				
43.00	NURSERY	0	0				
44.00	SKILLED NURSING FACILITY	3,259	134,988				
200.00	Total (lines 30 through 199)	9,320	752,039				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0058	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part II Date/Time Prepared: 2/26/2019 11:50 am
--	--	-----------------------	---	---

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	
Title XVIII Hospital PPS							
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,215,213	52,633,969	0.023088	4,723,135	109,048	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	51,608	1,467,494	0.035167	8,469	298	52.00
53.00	05300 ANESTHESIOLOGY	65,071	7,889,711	0.008248	406,389	3,352	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,653,882	120,405,492	0.013736	8,258,824	113,443	54.00
60.00	06000 LABORATORY	349,701	45,032,261	0.007766	8,410,523	65,316	60.00
65.00	06500 RESPIRATORY THERAPY	211,606	22,475,065	0.009415	5,231,718	49,257	65.00
66.00	06600 PHYSICAL THERAPY	424,969	27,945,172	0.015207	1,596,451	24,277	66.00
68.00	06800 SPEECH PATHOLOGY	8,605	1,372,901	0.006268	218,265	1,368	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	201	101,835	0.001974	9,893	20	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	187,834	6,560,275	0.028632	3,006,451	86,081	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	12,118	5,798,892	0.002090	1,636,875	3,421	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	99,835	25,476,397	0.003919	5,287,922	20,723	73.00
74.00	07400 RENAL DIALYSIS	22,613	665,823	0.033962	479,719	16,292	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	52,955	644,452	0.082171	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	1,955	1,246,849	0.001568	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	100,584	3,392,480	0.029649	14,716	436	90.00
91.00	09100 EMERGENCY	579,770	27,759,197	0.020886	2,588,501	54,063	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	50,215	801,336	0.062664	82,688	5,182	92.00
200.00	Total (lines 50 through 199)	5,088,735	351,669,601		41,960,539	552,577	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 14-0058	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part III Date/Time Prepared: 2/26/2019 11:50 am
---	--	-----------------------	---	--

Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00	
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 col. 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	9,999	0.00	5,048	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	1,238	0.00	668	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	2,370	0.00	345	40.00	
43.00	04300	NURSERY	0	0	788	0.00	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	4,482	0.00	3,259	44.00	
200.00		Total (lines 30 through 199)	0	0	18,877	0.00	9,320	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
40.00	04000	SUBPROVIDER - IPF	0						40.00
43.00	04300	NURSERY	0						43.00
44.00	04400	SKILLED NURSING FACILITY	0						44.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0058	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/26/2019 11:50 am
--	-----------------------	---	---

Cost Center Description	Title XVIII		Hospital		PPS	
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
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 PART)	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: 14-0058	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/26/2019 11:50 am
--	-----------------------	---	---

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	52,633,969	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,467,494	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	7,889,711	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	120,405,492	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	45,032,261	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	22,475,065	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	27,945,172	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,372,901	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	101,835	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,560,275	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,798,892	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	25,476,397	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	665,823	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	644,452	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	1,246,849	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	3,392,480	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	27,759,197	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	801,336	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	351,669,601		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0058	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/26/2019 11:50 am
--	-----------------------	---	---

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)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	4,723,135	0	9,778,433	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	8,469	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	406,389	0	890,777	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	8,258,824	0	36,320,434	0	54.00
60.00	06000 LABORATORY	0.000000	8,410,523	0	6,515,344	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	5,231,718	0	3,538,831	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	1,596,451	0	53,628	0	66.00
68.00	06800 SPEECH PATHOLOGY	0.000000	218,265	0	2,512	0	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	9,893	0	14,133	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	3,006,451	0	1,634,946	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,636,875	0	534,436	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	5,287,922	0	4,451,350	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	479,719	0	0	0	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	316,701	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	866,838	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	14,716	0	1,254,074	0	90.00
91.00	09100 EMERGENCY	0.000000	2,588,501	0	5,796,000	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	82,688	0	219,047	0	92.00
200.00	Total (lines 50 through 199)		41,960,539	0	72,187,484	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0058	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part V Date/Time Prepared: 2/26/2019 11:50 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	0.237871	9,778,433	0	0	2,326,006	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.384177	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.118413	890,777	0	0	105,480	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.090308	36,320,434	0	0	3,280,026	54.00
60.00	06000	LABORATORY	0.166922	6,515,344	0	0	1,087,554	60.00
65.00	06500	RESPIRATORY THERAPY	0.128180	3,538,831	0	0	453,607	65.00
66.00	06600	PHYSICAL THERAPY	0.295172	53,628	0	0	15,829	66.00
68.00	06800	SPEECH PATHOLOGY	0.282548	2,512	0	0	710	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.129749	14,133	0	0	1,834	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.145613	1,634,946	120	0	238,069	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.364738	534,436	0	0	194,929	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.272611	4,451,350	0	66,124	1,213,487	73.00
74.00	07400	RENAL DIALYSIS	0.139726	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.584458	316,701	0	0	185,098	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.142567	866,838	0	0	123,582	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.484268	1,254,074	0	0	607,308	90.00
91.00	09100	EMERGENCY	0.339924	5,796,000	0	0	1,970,200	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.816551	219,047	0	0	178,863	92.00
200.00		Subtotal (see instructions)		72,187,484	120	66,124	11,982,582	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		72,187,484	120	66,124	11,982,582	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0058	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part V Date/Time Prepared: 2/26/2019 11:50 am
Title XVIII		Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	18,026	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Subtotal (see instructions)	17	18,026	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	17	18,026	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0058 Component CCN: 14-S058		Period: From 10/01/2017 To 09/30/2018		Worksheet D Part II Date/Time Prepared: 2/26/2019 11:50 am	
				Title XVIII		Subprovider - IPF	PPS
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,215,213	52,633,969	0.023088	0	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	51,608	1,467,494	0.035167	0	0 52.00
53.00	05300	ANESTHESIOLOGY	65,071	7,889,711	0.008248	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,653,882	120,405,492	0.013736	27,189	373 54.00
60.00	06000	LABORATORY	349,701	45,032,261	0.007766	98,070	762 60.00
65.00	06500	RESPIRATORY THERAPY	211,606	22,475,065	0.009415	28,183	265 65.00
66.00	06600	PHYSICAL THERAPY	424,969	27,945,172	0.015207	30,189	459 66.00
68.00	06800	SPEECH PATHOLOGY	8,605	1,372,901	0.006268	0	0 68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	201	101,835	0.001974	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	187,834	6,560,275	0.028632	1,085	31 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,118	5,798,892	0.002090	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	99,835	25,476,397	0.003919	92,053	361 73.00
74.00	07400	RENAL DIALYSIS	22,613	665,823	0.033962	0	0 74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0 76.00
76.97	07697	CARDIAC REHABILITATION	52,955	644,452	0.082171	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,955	1,246,849	0.001568	0	0 76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	100,584	3,392,480	0.029649	0	0 90.00
91.00	09100	EMERGENCY	579,770	27,759,197	0.020886	23,113	483 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	801,336	0.000000	0	0 92.00
200.00		Total (lines 50 through 199)	5,038,520	351,669,601		299,882	2,734 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0058 Component CCN: 14-S058	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/26/2019 11:50 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
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 PART)	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 PASSTHROUGH COSTS	Provider CCN: 14-0058 Component CCN: 14-S058	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/26/2019 11:50 am
---	---	---	---

	Title XVIII	Subprovider - IPF	PPS
--	-------------	----------------------	-----

Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col.s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col.s. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7)	
		4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	52,633,969	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	1,467,494	0.000000	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	7,889,711	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	120,405,492	0.000000	54.00
60.00	06000 LABORATORY	0	0	0	45,032,261	0.000000	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	22,475,065	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	27,945,172	0.000000	66.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	1,372,901	0.000000	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	101,835	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,560,275	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,798,892	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	25,476,397	0.000000	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	665,823	0.000000	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	644,452	0.000000	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	1,246,849	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	3,392,480	0.000000	90.00
91.00	09100 EMERGENCY	0	0	0	27,759,197	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	801,336	0.000000	92.00
200.00	Total (lines 50 through 199)	0	0	0	351,669,601		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 14-0058 Component CCN: 14-S058		Period: From 10/01/2017 To 09/30/2018		Worksheet D Part IV Date/Time Prepared: 2/26/2019 11:50 am	
				Title XVIII		Subprovider - IPF	PPS
Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	27,189	0	0	0	54.00
60.00	06000 LABORATORY	0.000000	98,070	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	28,183	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	30,189	0	0	0	66.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,085	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	92,053	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	23,113	0	70	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00	Total (lines 50 through 199)		299,882	0	70	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0058 Component CCN: 14-S058	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part V Date/Time Prepared: 2/26/2019 11:50 am
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			PPS Services (see inst.)	Costs (see inst.)	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0.237871	0	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.384177	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.118413	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.090308	0	0	0	0	0	54.00
60.00 06000 LABORATORY	0.166922	0	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0.128180	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.295172	0	0	0	0	0	66.00
68.00 06800 SPEECH PATHOLOGY	0.282548	0	0	0	0	0	68.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.129749	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.145613	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.364738	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.272611	0	0	0	988	0	73.00
74.00 07400 RENAL DIALYSIS	0.139726	0	0	0	0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0.584458	0	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.142567	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	0.484268	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0.339924	70	0	0	0	24	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.816551	0	0	0	0	0	92.00
200.00	Subtotal (see instructions)	70	0	0	988	24	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 - line 201)		70	0	988	24	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0058 Component CCN: 14-S058	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part V Date/Time Prepared: 2/26/2019 11:50 am
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00 06000 LABORATORY	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	269	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
OUTPATIENT SERVICE COST CENTERS			
90.00 09000 CLINIC	0	0	90.00
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00 Subtotal (see instructions)	0	269	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 - line 201)	0	269	202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0058 Component CCN: 14-5951	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/26/2019 11:50 am
Title XVIII		Skilled Nursing Facility	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
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 PART)	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 PASSTHROUGH COSTS	Provider CCN: 14-0058 Component CCN: 14-5951	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/26/2019 11:50 am
---	---	---	---

	Title XVIII	Skilled Nursing Facility	PPS
--	-------------	--------------------------	-----

Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7)	
		4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	52,633,969	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	1,467,494	0.000000	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	7,889,711	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	120,405,492	0.000000	54.00
60.00	06000 LABORATORY	0	0	0	45,032,261	0.000000	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	22,475,065	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	27,945,172	0.000000	66.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	1,372,901	0.000000	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	101,835	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,560,275	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,798,892	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	25,476,397	0.000000	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	665,823	0.000000	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	644,452	0.000000	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	1,246,849	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	3,392,480	0.000000	90.00
91.00	09100 EMERGENCY	0	0	0	27,759,197	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	801,336	0.000000	92.00
200.00	Total (lines 50 through 199)	0	0	0	351,669,601		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 14-0058 Component CCN: 14-5951		Period: From 10/01/2017 To 09/30/2018		Worksheet D Part IV Date/Time Prepared: 2/26/2019 11:50 am	
		Title XVIII		Skilled Nursing Facility		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	2,030	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	172,747	0	0	0	54.00
60.00	06000 LABORATORY	0.000000	684,003	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	774,005	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	2,146,277	0	0	0	66.00
68.00	06800 SPEECH PATHOLOGY	0.000000	55,947	0	0	0	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	306,605	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	952,235	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	6,954	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	2,548	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00	Total (lines 50 through 199)		5,103,351	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0058 Component CCN: 14-5951	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part V Date/Time Prepared: 2/26/2019 11:50 am
Title XVIII		Skilled Nursing Facility	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			PPS 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					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.237871	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.384177	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.118413	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.090308	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0.166922	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.128180	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.295172	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.282548	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.129749	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.145613	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.364738	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.272611	0	0	7,490	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.139726	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.584458	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.142567	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.484268	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.339924	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.816551	0	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	7,490	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	7,490	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0058 Component CCN: 14-5951	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part V Date/Time Prepared: 2/26/2019 11:50 am
	Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00 06000 LABORATORY	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	2,042	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
OUTPATIENT SERVICE COST CENTERS			
90.00 09000 CLINIC	0	0	90.00
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00 Subtotal (see instructions)	0	2,042	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 - line 201)	0	2,042	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0058	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/26/2019 11:50 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)		9,999	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		9,999	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)		9,466	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)		5,048	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)		12,275,154	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)		12,275,154	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)		12,275,154	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)		1,227.64	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		6,197,127	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		6,197,127	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0058		Period: From 10/01/2017 To 09/30/2018		Worksheet D-1 Date/Time Prepared: 2/26/2019 11:50 am	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
NURSERY (title V & XIX only)		1.00	2.00	3.00	4.00	5.00	
42.00	Intensive Care Type Inpatient Hospital Units	0	0	0.00	0	0	42.00
43.00	INTENSIVE CARE UNIT	3,214,422	1,238	2,596.46	668	1,734,435	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)					8,027,871	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					15,959,433	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)					590,976	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					552,577	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,143,553	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					14,815,880	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)					533	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,227.64	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					654,332	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0058		Period: From 10/01/2017 To 09/30/2018		Worksheet D-1 Date/Time Prepared: 2/26/2019 11:50 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	942,038	12,275,154	0.076743	654,332	50,215	90.00
91.00	Nursing School cost	0	12,275,154	0.000000	654,332	0	91.00
92.00	Allied health cost	0	12,275,154	0.000000	654,332	0	92.00
93.00	All other Medical Education	0	12,275,154	0.000000	654,332	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0058 Component CCN: 14-S058	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/26/2019 11:50 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,370	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,370	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,370	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)		345	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,021,096	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,021,096	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,021,096	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)		1,274.72	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		439,778	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)		439,778	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0058		Period: From 10/01/2017 To 09/30/2018		Worksheet D-1		
		Component CCN: 14-S058				Date/Time Prepared: 2/26/2019 11:50 am		
		Title XVIII		Subprovider - IPF		PPS		
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)			
	1.00	2.00	3.00	4.00	5.00			
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00	
Intensive Care Type Inpatient Hospital Units								
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00	
44.00 CORONARY CARE UNIT							44.00	
45.00 BURN INTENSIVE CARE UNIT							45.00	
46.00 SURGICAL INTENSIVE CARE UNIT							46.00	
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00	
Cost Center Description					1.00			
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					64,461		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					504,239		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)					26,075		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,734		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					28,809		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					475,430		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: 14-0058 Component CCN: 14-S058		Period: From 10/01/2017 To 09/30/2018		Worksheet D-1 Date/Time Prepared: 2/26/2019 11:50 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	179,127	3,021,096	0.059292	0	0	90.00
91.00	Nursing School cost	0	3,021,096	0.000000	0	0	91.00
92.00	Allied health cost	0	3,021,096	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,021,096	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0058 Component CCN: 14-5951	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/26/2019 11:50 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,482	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,482	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		4,482	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		3,259	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)		2,579,227	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)		2,579,227	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)		2,579,227	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)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0058 Component CCN: 14-5951		Period: From 10/01/2017 To 09/30/2018		Worksheet D-1 Date/Time Prepared: 2/26/2019 11:50 am	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						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)						48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						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)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						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						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						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)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						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)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						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)						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)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						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)					2,579,227	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					575.46	71.00
72.00	Program routine service cost (line 9 x line 71)					1,875,424	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					1,875,424	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)					0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00	Inpatient routine service cost per diem limitation					0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)					1,875,424	83.00
84.00	Program inpatient ancillary services (see instructions)					1,187,333	84.00
85.00	Utilization review - physician compensation (see instructions)					0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					3,062,757	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: 14-0058 Component CCN: 14-5951		Period: From 10/01/2017 To 09/30/2018		Worksheet D-1 Date/Time Prepared: 2/26/2019 11:50 am	
		Title XVIII		Skilled Nursing Facility		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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0058	Period: From 10/01/2017 To 09/30/2018	Worksheet D-3 Date/Time Prepared: 2/26/2019 11:50 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		9,938,937	30.00
31.00	03100	INTENSIVE CARE UNIT		3,517,267	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.237871	4,723,135	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.384177	8,469	52.00
53.00	05300	ANESTHESIOLOGY	0.118413	406,389	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.090330	8,258,824	54.00
60.00	06000	LABORATORY	0.166922	8,410,523	60.00
65.00	06500	RESPIRATORY THERAPY	0.128248	5,231,718	65.00
66.00	06600	PHYSICAL THERAPY	0.295172	1,596,451	66.00
68.00	06800	SPEECH PATHOLOGY	0.282548	218,265	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.129749	9,893	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.145613	3,006,451	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.364738	1,636,875	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.272611	5,287,922	73.00
74.00	07400	RENAL DIALYSIS	0.139726	479,719	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.584458	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.142567	0	76.98
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.485262	14,716	90.00
91.00	09100	EMERGENCY	0.339924	2,588,501	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.816551	82,688	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		41,960,539	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)		41,960,539	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0058 Component CCN: 14-S058	Period: From 10/01/2017 To 09/30/2018	Worksheet D-3 Date/Time Prepared: 2/26/2019 11:50 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
40.00	04000 SUBPROVIDER - IPF		477,199	40.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.237871	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.384177	0	52.00
53.00	05300 ANESTHESIOLOGY	0.118413	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.090330	27,189	54.00
60.00	06000 LABORATORY	0.166922	98,070	60.00
65.00	06500 RESPIRATORY THERAPY	0.128248	28,183	65.00
66.00	06600 PHYSICAL THERAPY	0.295172	30,189	66.00
68.00	06800 SPEECH PATHOLOGY	0.282548	0	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.129749	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.145613	1,085	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.364738	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.272611	92,053	73.00
74.00	07400 RENAL DIALYSIS	0.139726	0	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.584458	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.142567	0	76.98
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.485262	0	90.00
91.00	09100 EMERGENCY	0.339924	23,113	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.816551	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		299,882	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)		299,882	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0058 Component CCN: 14-5951	Period: From 10/01/2017 To 09/30/2018	Worksheet D-3 Date/Time Prepared: 2/26/2019 11:50 am	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.237871	2,030	483	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.384177	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.118413	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.090330	172,747	15,604	54.00
60.00	06000 LABORATORY	0.166922	684,003	114,175	60.00
65.00	06500 RESPIRATORY THERAPY	0.128248	774,005	99,265	65.00
66.00	06600 PHYSICAL THERAPY	0.295172	2,146,277	633,521	66.00
68.00	06800 SPEECH PATHOLOGY	0.282548	55,947	15,808	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.129749	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.145613	306,605	44,646	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.364738	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.272611	952,235	259,590	73.00
74.00	07400 RENAL DIALYSIS	0.139726	0	0	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.584458	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.142567	0	0	76.98
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.485262	6,954	3,375	90.00
91.00	09100 EMERGENCY	0.339924	2,548	866	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.816551	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		5,103,351	1,187,333	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)		5,103,351		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0058	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part A Date/Time Prepared: 2/26/2019 11:50 am
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		10,312,610	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)		145,241	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)		82.23	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)		4.97	30.00
31.00	Percentage of Medicaid patient days (see instructions)		21.86	31.00
32.00	Sum of lines 30 and 31		26.83	32.00
33.00	Allowable disproportionate share percentage (see instructions)		11.35	33.00
34.00	Disproportionate share adjustment (see instructions)		292,620	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0058	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part A Date/Time Prepared: 2/26/2019 11:50 am	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	6,766,695,164	35.00
35.01	Factor 3 (see instructions)		0.000000000	0.000061218	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	414,244	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	414,244	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		414,244		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		11,164,715		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		13,614,853		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			13,614,853	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			846,558	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			0	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			14,461,411	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			14,461,411	61.00
62.00	Deductibles billed to program beneficiaries			1,403,412	62.00
63.00	Coinurance billed to program beneficiaries			26,118	63.00
64.00	Allowable bad debts (see instructions)			335,841	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			218,297	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			312,954	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			13,250,178	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)				70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			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)			82,184	70.93
70.94	HRR adjustment amount (see instructions)			-21,657	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0058	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part A Date/Time Prepared: 2/26/2019 11:50 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)		13,310,705	71.00
71.01	Sequestration adjustment (see instructions)		266,214	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		13,170,805	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)		-126,314	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)			0
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
2/26/2019 11:50 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0	0	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	10,312,610	0	0	10,312,610	10,312,610	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	145,241	0	0	145,241	145,241	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	0.000000	5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	0.000000	7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1135	0.1135	0.1135	0.1135	0.1135	10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	292,620	0	0	292,620	292,620	11.00
11.01	Uncompensated care payments	36.00	414,244	0	0	414,244	414,244	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	11,164,715	0	0	11,164,715	11,164,715	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	13,614,853	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	13,614,853	0	0	13,614,853	13,614,853	15.00
16.00	Payment for inpatient program capital (From Wkst. L, Pt. I, if applicable)	50.00	846,558	0	0	846,558	846,558	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ acquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
2/26/2019 11:50 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	0	14,461,411	14,461,411	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	833,395	0	0	833,395	833,395	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	13,163	0	0	13,163	13,163	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	846,558	0	0	846,558	846,558	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: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet E
Part A Exhibit 5
Date/Time Prepared:
2/26/2019 11:50 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	0	0	0	0	1.01	
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	10,312,610		10,312,610	10,312,610	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	1.04	
2.00	Outlier payments for discharges (see instructions)	2.00	145,241	0	145,241	145,241	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	0.1135	0.1135	0.1135		10.00	
11.00	Disproportionate share adjustment (see instructions)	34.00	292,620	0	292,620	292,620	11.00	
11.01	Uncompensated care payments	36.00	414,244	0	414,244	414,244	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	11,164,715	0	11,164,715	11,164,715	13.00	
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	13,614,853	0	0	0	14.00	
15.00	Total payment for inpatient operating costs (see instructions)	49.00	13,614,853	0	13,614,853	13,614,853	15.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	846,558	0	846,558	846,558	16.00	
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00	
17.01	Net organ acquisition cost						17.01	
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00	
19.00	SUBTOTAL			0	14,461,411	14,461,411	19.00	

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	833,395	0	833,395	833,395	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	13,163	0	13,163	13,163	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	846,558	0	846,558	846,558	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	82,184	0	82,184	82,184	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	-21,657	0	-21,657	-21,657	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: 14-0058	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part B Date/Time Prepared: 2/26/2019 11:50 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		18,043	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		11,982,582	2.00
3.00	OPPS payments		10,704,969	3.00
4.00	Outlier payment (see instructions)		15,934	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)		18,043	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		66,244	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)		66,244	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)		66,244	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		48,201	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)		18,043	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)		10,720,903	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		24	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,214,711	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)		8,524,211	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)		8,524,211	30.00
31.00	Primary payer payments		4,053	31.00
32.00	Subtotal (line 30 minus line 31)		8,520,158	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)		545,639	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		354,665	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		513,610	36.00
37.00	Subtotal (see instructions)		8,874,823	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		8,874,823	40.00
40.01	Sequestration adjustment (see instructions)		177,496	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		8,665,347	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		31,980	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0058 Component CCN: 14-S058	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part B Date/Time Prepared: 2/26/2019 11:50 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		269	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		24	2.00
3.00	OPPS payments		32	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		269	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		988	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)		988	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)		988	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		719	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)		269	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)		32	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)		0	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)		301	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)		301	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		301	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)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		301	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		301	40.00
40.01	Sequestration adjustment (see instructions)		6	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		196	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		99	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0058 Component CCN: 14-5951	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part B Date/Time Prepared: 2/26/2019 11:50 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		2,042	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
4.01	Outlier reconciliation amount (see instructions)			4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			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)		2,042	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		7,490	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)		7,490	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)		7,490	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		5,448	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		2,042	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)		0	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)			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)		2,042	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)		2,042	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		2,042	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)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		2,042	37.00
38.00	MSP-LCC reconciliation amount from PS&R			38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment 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)		2,042	40.00
40.01	Sequestration adjustment (see instructions)		41	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		1,688	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		313	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)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet E-1
Part I
Date/Time Prepared:
2/26/2019 11:50 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		13,170,805		8,665,347	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		13,170,805		8,665,347	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		31,980	6.01	
6.02	SETTLEMENT TO PROGRAM		126,314		0	6.02	
7.00	Total Medicare program liability (see instructions)		13,044,491		8,697,327	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: 14-0058
Component CCN: 14-S058

Period:
From 10/01/2017
To 09/30/2018

Worksheet E-1
Part I
Date/Time Prepared:
2/26/2019 11:50 am

Title XVIII

Subprovider -
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		264,450		196	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		264,450		196	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		99	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		264,450		295	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: 14-0058
Component CCN: 14-5951

Period:
From 10/01/2017
To 09/30/2018

Worksheet E-1
Part I
Date/Time Prepared:
2/26/2019 11:50 am

Title XVIII

Skilled Nursing
Facility

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1,131,363		1,688	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)		0		0	3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,131,363		1,688	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		313	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,131,363		2,001	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0058	Period: From 10/01/2017 To 09/30/2018	Worksheet E-1 Part II Date/Time Prepared: 2/26/2019 11:50 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: 14-0058 Component CCN: 14-S058	Period: From 10/01/2017 To 09/30/2018	Worksheet E-3 Part II Date/Time Prepared: 2/26/2019 11:50 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			303,838 1.00
2.00	Net IPF PPS Outlier Payments			657 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			6.493151 9.00
10.00	Teaching Adjustment Factor $\{(1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			304,495 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			304,495 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			304,495 18.00
19.00	Deductibles			34,648 19.00
20.00	Subtotal (line 18 minus line 19)			269,847 20.00
21.00	Coinurance			0 21.00
22.00	Subtotal (line 20 minus line 21)			269,847 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			0 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 25.00
26.00	Subtotal (sum of lines 22 and 24)			269,847 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			269,847 31.00
31.01	Sequestration adjustment (see instructions)			5,397 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			264,450 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			0 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			657 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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0058 Component CCN: 14-5951	Period: From 10/01/2017 To 09/30/2018	Worksheet E-3 Part VI Date/Time Prepared: 2/26/2019 11:50 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		1,269,870	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		1,269,870	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		115,418	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		1,154,452	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.99	Demonstration payment adjustment amount before sequestration		0	14.99
15.00	Subtotal (see instructions)		1,154,452	15.00
15.01	Sequestration adjustment (see instructions)		23,089	15.01
15.02	Demonstration payment adjustment amount after sequestration		0	15.02
16.00	Interim payments		1,131,363	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)		0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

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

Provider CCN: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet G

Date/Time Prepared:
2/26/2019 11:50 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	4,931,004	0	0	0	1.00
2.00	Temporary investments	3,725,726	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	72,844,806	0	0	0	4.00
5.00	Other receivable	971,409	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-55,245,764	0	0	0	6.00
7.00	Inventory	1,715,321	0	0	0	7.00
8.00	Prepaid expenses	995,785	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)	29,938,287	0	0	0	11.00
FIXED ASSETS						
12.00	Land	735,200	0	0	0	12.00
13.00	Land improvements	1,263,246	0	0	0	13.00
14.00	Accumulated depreciation	-229,572	0	0	0	14.00
15.00	Buildings	11,111,857	0	0	0	15.00
16.00	Accumulated depreciation	-1,671,773	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	19,067,588	0	0	0	19.00
20.00	Accumulated depreciation	-4,459,843	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	19,615,434	0	0	0	23.00
24.00	Accumulated depreciation	-8,474,752	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	702,567	0	0	0	27.00
28.00	Accumulated depreciation	-693,324	0	0	0	28.00
29.00	Minor equipment-nondepreciable	1,707,052	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	38,673,680	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	83,042,270	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	24,000,021	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	107,042,291	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	175,654,258	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	3,108,960	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,330,816	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,308,000	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	5,364,175	0	0	0	43.00
44.00	Other current liabilities	444,712	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	15,556,663	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	18,869,958	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	7,927,238	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	26,797,196	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	42,353,859	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	133,300,399				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	133,300,399	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	175,654,258	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet G-1

Date/Time Prepared:
2/26/2019 11:50 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		125,715,686		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		12,248,268			2.00
3.00	Total (sum of line 1 and line 2)		137,963,954		0	3.00
4.00	INTEREST IN TRUST ACCOUNTS	165,326		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		165,326		0	10.00
11.00	Subtotal (line 3 plus line 10)		138,129,280		0	11.00
12.00	TRANSFER TO/FROM RELATED ORGS	4,828,881		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		4,828,881		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		133,300,399		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	INTEREST IN TRUST ACCOUNTS		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	TRANSFER TO/FROM RELATED ORGS		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: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet G-2
Parts I & II
Date/Time Prepared:
2/26/2019 11:50 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	19,877,823		19,877,823	1.00
2.00	SUBPROVIDER - IPF	3,407,182		3,407,182	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	7,563,154		7,563,154	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)	30,848,159		30,848,159	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	6,446,563		6,446,563	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)	6,446,563		6,446,563	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	37,294,722		37,294,722	17.00
18.00	Ancillary services	80,355,785	248,393,346	328,749,131	18.00
19.00	Outpatient services	5,055,786	27,477,118	32,532,904	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	PROFEE	0	24,819	24,819	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	122,706,293	275,895,283	398,601,576	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		102,843,251		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)		102,843,251		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0058

Period:
From 10/01/2017
To 09/30/2018

Worksheet G-3

Date/Time Prepared:
2/26/2019 11:50 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	398,601,576	1.00
2.00	Less contractual allowances and discounts on patients' accounts	289,171,428	2.00
3.00	Net patient revenues (line 1 minus line 2)	109,430,148	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	102,843,251	4.00
5.00	Net income from service to patients (line 3 minus line 4)	6,586,897	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	185,487	6.00
7.00	Income from investments	11,014,649	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	584,682	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	26,189	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	13,040	21.00
22.00	Rental of hospital space	433,061	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	553,085	24.00
24.01	LIFELINE	342,529	24.01
24.02	EHR	0	24.02
24.03	ASSESSMENT PUBLIC AID	0	24.03
24.04	UNREALIZED GAINS-LOSSES	0	24.04
25.00	Total other income (sum of lines 6-24)	13,152,722	25.00
26.00	Total (line 5 plus line 25)	19,739,619	26.00
27.00	NON OPERATING EXPENSE	482,936	27.00
27.01	CHANGE IN INTEREST	-154,347	27.01
27.02	NI OM TEMP RESTRICTED FUND	-3,547	27.02
27.03	UNREALIZED GAINS-LOSSES	6,818,804	27.03
27.04	RETIREE BENEFIT ADJUSTMENT	347,505	27.04
28.00	Total other expenses (sum of line 27 and subscripts)	7,491,351	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	12,248,268	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0058	Period: From 10/01/2017 To 09/30/2018	Worksheet L Parts I-III Date/Time Prepared: 2/26/2019 11:50 am
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		833,395	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		13,163	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)		30.28	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)		846,558	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