

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

OMB NO. 0938-0050  
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0197	Period: From 10/01/2017 To 09/30/2018	Worksheet S Parts I-III Date/Time Prepared: 2/27/2019 3:19 pm
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**PART I - COST REPORT STATUS**

Provider use only

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

Date: 2/27/2019 Time: 3:19 pm

Contractor use only

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

6. Date Received:  
 7. Contractor No.

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

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

**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 METHODIST HOSPITAL OF CHICAGO ( 14-0197 ) 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	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	416,790	-5,656	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I						4.00
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	0		0	7.00
8.00 NURSING FACILITY	0				0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0				0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0				0	11.00
12.00 CMHC I	0				0	12.00
200.00 Total	0	416,790	-5,656	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: 14-0197		Period: From 10/01/2017 To 09/30/2018		Worksheet S-2 Part I Date/Time Prepared: 2/27/2019 3:19 pm					
1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 State: IL		4.00 Zip Code: 60640-2772 County: COOK					
1.00 Street: 5025 N PAULINA ST		2.00 City: CHICAGO									
Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)					
1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00			
3.00 Hospital and Hospital-Based Component Identification:											
3.00	Hospital	METHODIST HOSPITAL OF CHICAGO	140197	16974	1	07/01/1966	N	P	N	3.00	
4.00	Subprovider - IPF									4.00	
5.00	Subprovider - IRF									5.00	
6.00	Subprovider - (Other)									6.00	
7.00	Swing Beds - SNF									7.00	
8.00	Swing Beds - NF									8.00	
9.00	Hospital-Based SNF									9.00	
10.00	Hospital-Based NF									10.00	
11.00	Hospital-Based OLTC									11.00	
12.00	Hospital-Based HHA									12.00	
13.00	Separately Certified ASC									13.00	
14.00	Hospital-Based Hospice									14.00	
15.00	Hospital-Based Health Clinic - RHC									15.00	
16.00	Hospital-Based Health Clinic - FQHC									16.00	
17.00	Hospital-Based (CMHC) I									17.00	
17.10	Hospital-Based (CORF) I									17.10	
18.00	Renal Dialysis									18.00	
19.00	Other									19.00	
					From:		To:				
					1.00		2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)				10/01/2017		09/30/2018		20.00		
21.00	Type of Control (see instructions)				2				21.00		
					1.00	2.00	3.00				
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				Y	N		22.00			
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				N	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.				1,436	222	0	0	8,583	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0197			Period: From 10/01/2017 To 09/30/2018		Worksheet S-2 Part I Date/Time Prepared: 2/27/2019 3:19 pm				
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days				
		1.00	2.00	3.00	4.00	5.00	6.00				
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0		25.00		
						Urban/Rural S		Date of Geogr			
						1.00		2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.							1		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.							1		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.							0		35.00	
						Beginning:		Ending:			
						1.00		2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.									36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.							0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)									37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.									38.00	
						Y/N		Y/N			
						1.00		2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)							N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)							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	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.							N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.							N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.							N	N	N	48.00
Teaching Hospitals											
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.							N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.							N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.							N			59.00
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criteria Code					
				1.00	2.00	3.00					
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)							N			60.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0197		Period: From 10/01/2017 To 09/30/2018		Worksheet S-2 Part I Date/Time Prepared: 2/27/2019 3:19 pm		
		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.						109.00	
					1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N		110.00	
					1.00	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.				N		111.00	
					1.00	2.00	3.00	
<b>Miscellaneous Cost Reporting Information</b>								
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.				N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.				N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.				Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.				2			118.00
		Premiums		Losses		Insurance		
		1.00		2.00		3.00		
118.01	List amounts of malpractice premiums and paid losses:	52,887		0		0		118.01
				1.00		2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.				N			118.02
119.00	DO NOT USE THIS LINE							119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.				N	N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.				Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.				N			122.00
<b>Transplant Center Information</b>								
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.				N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.							134.00
All Providers								

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0197		Period: From 10/01/2017 To 09/30/2018		Worksheet S-2 Part I Date/Time Prepared: 2/27/2019 3:19 pm	
		1.00	2.00				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y				140.00	
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
						1.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y					145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N					146.00
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
161.10	CORF		N	N	N	161.10	
						1.00	
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name		County		State	
		0		1.00		2.00	
						Zip Code	
						3.00	
						CBSA	
						4.00	
						FTE/Campus	
						5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					0	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					0.00	
				Beginning		Ending	
				1.00		2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			10/01/2017		09/30/2018	
						170.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0197	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part I Date/Time Prepared: 2/27/2019 3:19 pm
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0197		Period: From 10/01/2017 To 09/30/2018		Worksheet S-2 Part II Date/Time Prepared: 2/27/2019 3:19 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	04/30/2019			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	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)	Y	01/15/2019	Y	01/15/2019		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0197	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part II Date/Time Prepared: 2/27/2019 3:19 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N	N	21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?		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		
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JAMES		GREGORY	41.00
42.00	Enter the employer/company name of the cost report preparer.	BETHANY METHODIST CORPORATION			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	773-989-1469		JGREGORY@BETHANYMETHODIST.ORG	43.00

		3.00	
<b>Cost Report Preparer Contact Information</b>			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CORPORATE CONTROLLER	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: 14-0197

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/27/2019 3:19 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps	
					Ti tle 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	136	49,640	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)		136	49,640	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	32.00	0	0	0.00	0	9.00
10.00 BURN INTENSIVE CARE UNIT	33.00	0	0	0.00	0	10.00
11.00 SURGICAL INTENSIVE CARE UNIT	34.00	0	0	0.00	0	11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		145	52,925	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00 NURSING FACILITY	45.00	0	0		0	20.00
21.00 OTHER LONG TERM CARE	46.00	0	0		0	21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)	115.00					23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC	99.00				0	25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		145				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: 14-0197

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/27/2019 3:19 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII	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)	5,082	1,574	17,433			1.00
2.00 HMO and other (see instructions)	1,464	8,583				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	5,082	1,574	17,433			7.00
8.00 INTENSIVE CARE UNIT	133	84	857			8.00
9.00 CORONARY CARE UNIT	0	0	0			9.00
10.00 BURN INTENSIVE CARE UNIT	0	0	0			10.00
11.00 SURGICAL INTENSIVE CARE UNIT	0	0	0			11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		0	0			13.00
14.00 Total (see instructions)	5,215	1,658	18,290	0.00	428.48	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00 SUBPROVIDER		0	0	0.00	0.00	18.00
19.00 SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00 NURSING FACILITY		0	0	0.00	0.00	20.00
21.00 OTHER LONG TERM CARE		0	0	0.00	0.00	21.00
22.00 HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				0.00	0.00	23.00
24.00 HOSPICE	0	0	0	0.00	0.00	24.00
24.10 HOSPICE (non-distinct part)			0			24.10
25.00 CMHC - CMHC	0	0	0	0.00	0.00	25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00 RURAL HEALTH CLINIC	0	0	0	0.00	0.00	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	428.48	27.00
28.00 Observation Bed Days		332	490			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			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: 14-0197

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/27/2019 3:19 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	961	289	3,818	1.00
2.00 HMO and other (see instructions)				281	1,955		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	961	289	3,818		14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF	0.00	0	0	0	0	0	16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	0	17.00
18.00 SUBPROVIDER	0.00	0	0	0	0	0	18.00
19.00 SKILLED NURSING FACILITY	0.00						19.00
20.00 NURSING FACILITY	0.00						20.00
21.00 OTHER LONG TERM CARE	0.00					0	21.00
22.00 HOME HEALTH AGENCY	0.00						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)	0.00						23.00
24.00 HOSPICE	0.00						24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC	0.00						25.00
25.10 CMHC - CORF	0.00						25.10
26.00 RURAL HEALTH CLINIC	0.00						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: 14-0197	Period: From 10/01/2017 To 09/30/2018	Worksheet S-3 Part II Date/Time Prepared: 2/27/2019 3:19 pm	
	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	16,902,879	778,787	17,681,666	910,556.00	19.42
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		574,173	-333,372	240,801	12,511.00	19.25
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract Labor: Direct Patient Care		0	0	0	0.00	0.00
12.00	Contract Labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		406,629	0	406,629	7,716.00	52.70
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) (see instructions)		3,576,401	0	3,576,401		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		49,130	0	49,130		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0197

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
2/27/2019 3:19 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
<b>OVERHEAD COSTS - DIRECT SALARIES</b>								
26.00	Employee Benefits Department	4.00	190,524	0	190,524	6,548.00	29.10	26.00
27.00	Administrative & General	5.00	1,703,554	537,986	2,241,540	39,115.00	57.31	27.00
28.00	Administrative & General under contract (see inst.)		88,304	0	88,304	889.00	99.33	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	947,152	0	947,152	70,577.00	13.42	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	480,117	0	480,117	38,184.00	12.57	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	755,214	-38,140	717,074	52,785.00	13.58	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	57,148	38,140	95,288	4,905.00	19.43	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	631,881	0	631,881	15,776.00	40.05	38.00
39.00	Central Services and Supply	14.00	75,909	0	75,909	4,912.00	15.45	39.00
40.00	Pharmacy	15.00	395,731	0	395,731	11,757.00	33.66	40.00
41.00	Medical Records & Medical Records Library	16.00	567,398	0	567,398	24,426.00	23.23	41.00
42.00	Social Service	17.00	149,883	0	149,883	5,627.00	26.64	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0197

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
2/27/2019 3:19 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion 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	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	16,991,183	778,787	17,769,970	911,445.00	19.50	1.00
2.00	Excluded area salaries (see instructions)	574,173	-333,372	240,801	12,511.00	19.25	2.00
3.00	Subtotal salaries (line 1 minus line 2)	16,417,010	1,112,159	17,529,169	898,934.00	19.50	3.00
4.00	Subtotal other wages & related costs (see inst.)	406,629	0	406,629	7,716.00	52.70	4.00
5.00	Subtotal wage-related costs (see inst.)	3,576,401	0	3,576,401	0.00	20.40	5.00
6.00	Total (sum of lines 3 thru 5)	20,400,040	1,112,159	21,512,199	906,650.00	23.73	6.00
7.00	Total overhead cost (see instructions)	6,042,815	537,986	6,580,801	275,501.00	23.89	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 14-0197	Period: From 10/01/2017 To 09/30/2018	Worksheet S-3 Part IV Date/Time Prepared: 2/27/2019 3:19 pm
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		Amount Reported	
		1.00	
<b>PART IV - WAGE RELATED COSTS</b>			
<b>Part A - Core List</b>			
<b>RETIREMENT COST</b>			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	597,833	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
<b>HEALTH AND INSURANCE COST</b>			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	1,387,232	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)	22,680	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	266,693	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
<b>TAXES</b>			
17.00	FICA-Employers Portion Only	1,279,885	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	70,828	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
<b>OTHER</b>			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	380	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	3,625,531	24.00
<b>Part B - Other than Core Related Cost</b>			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0197

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

Worksheet S-3  
Part V  
Date/Time Prepared:  
2/27/2019 3:19 pm

Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	3,625,531	1.00
2.00	Hospital	0	3,576,401	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF	0	0	9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC	0	0	12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC	0	0	16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	49,130	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0197	Period: From 10/01/2017 To 09/30/2018	Worksheet S-10 Date/Time Prepared: 2/27/2019 3:19 pm
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			1.00		
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.738611	1.00	
<b>Medicaid (see instructions for each line)</b>					
2.00	Net revenue from Medicaid		17,190,985	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		19,846,569	6.00	
7.00	Medicaid cost (line 1 times line 6)		14,658,894	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)		0	8.00	
<b>Children's Health Insurance Program (CHIP) (see instructions for each line)</b>					
9.00	Net revenue from stand-alone CHIP		0	9.00	
10.00	Stand-alone CHIP charges		0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
<b>Other state or local government indigent care program (see instructions for each line)</b>					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
<b>Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)</b>					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00	
			Uninsured patients	Insured patients	Total (col. 1 + col. 2)
			1.00	2.00	3.00
<b>Uncompensated Care (see instructions for each line)</b>					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	305,991	0	305,991	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	226,008	0	226,008	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	226,008	0	226,008	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)			1,615,773	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			392,895	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			604,454	27.01
28.00	Non-Medicare bad debt expense (see instructions)			1,011,319	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			958,530	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			1,184,538	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			1,184,538	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 14-0197		Period: From 10/01/2017 To 09/30/2018		Worksheet A			
Date/Time Prepared: 2/27/2019 3:19 pm									
Cost Center	Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)			
		1.00	2.00	3.00	4.00	5.00			
<b>GENERAL SERVICE COST CENTERS</b>									
1.00	00100	CAP REL COSTS-BLDG & FIXT		664,285		664,285	205,639	869,924	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		373,682		373,682	34,399	408,081	2.00
3.00	00300	OTHER CAP REL COSTS		0		0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	190,524	1,794,491	1,985,015	698,896		2,683,911	4.00
5.01	00540	NONPATIENT TELEPHONES	32,109	116,756	148,865	0		148,865	5.01
5.02	00550	DATA PROCESSING	262,739	281,176	543,915	0		543,915	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	274,910	-26,948	247,962	0		247,962	5.03
5.04	00570	ADMINISTRATION	268,803	121,252	390,055	0		390,055	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	49,776	477,791	527,567	0		527,567	5.05
5.06	00590	OTHER ADMINISTRATIVE & GENERAL	815,217	5,921,636	6,736,853	-1,013,863		5,722,990	5.06
7.00	00700	OPERATION OF PLANT	947,152	1,207,861	2,155,013	0		2,155,013	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	123,842	123,842	0		123,842	8.00
9.00	00900	HOUSEKEEPING	480,117	113,611	593,728	0		593,728	9.00
10.00	01000	DIETARY	755,214	61,878	817,092	-94,969		722,123	10.00
11.00	01100	CAFETERIA	57,148	9,125	66,273	94,969		161,242	11.00
13.00	01300	NURSING ADMINISTRATION	631,881	81,975	713,856	0		713,856	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	75,909	127,753	203,662	0		203,662	14.00
15.00	01500	PHARMACY	395,731	79,679	475,410	0		475,410	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	567,398	163,971	731,369	0		731,369	16.00
17.00	01700	SOCIAL SERVICE	149,883	21,784	171,667	0		171,667	17.00
18.00	01850	OTHER GEN SVC COST CTR	0	0	0	0		0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0		0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0		0	22.00
23.00	02300	PARAMED ED PROGRAM	0	0	0	0		0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>									
30.00	03000	ADULTS & PEDIATRICS	5,689,681	1,321,590	7,011,271	-674,051		6,337,220	30.00
31.00	03100	INTENSIVE CARE UNIT	0	18,000	18,000	674,051		692,051	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0		0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0		0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0		0	34.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0		0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0		0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0		0	42.00
43.00	04300	NURSERY	0	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0		0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0		0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	1,213,787	167,980	1,381,767	0		1,381,767	50.00
51.00	05100	RECOVERY ROOM	202,526	15,958	218,484	0		218,484	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		0	52.00
53.00	05300	ANESTHESIOLOGY	84,452	268,414	352,866	0		352,866	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	488,456	328,080	816,536	0		816,536	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0		0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0		0	56.00
57.00	05700	CT SCAN	0	0	0	0		0	57.00
58.00	05800	MRI	0	0	0	0		0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		0	59.00
60.00	06000	LABORATORY	773,857	756,414	1,530,271	0		1,530,271	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0		0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0		0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0		0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0		0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		0	64.00
65.00	06500	RESPIRATORY THERAPY	446,566	101,330	547,896	0		547,896	65.00
66.00	06600	PHYSICAL THERAPY	164,801	142,677	307,478	0		307,478	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		0	68.00
69.00	06900	ELECTROCARDIOLOGY	71,789	190,203	261,992	0		261,992	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	431,295	431,295	-11,702		419,593	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,702		11,702	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,680,922	1,680,922	0		1,680,922	73.00
74.00	07400	RENAL DIALYSIS	0	21,880	21,880	0		21,880	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0		0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		0	89.00
90.00	09000	CLINIC	0	0	0	0		0	90.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0197

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

Worksheet A  
Date/Time Prepared:  
2/27/2019 3:19 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
90.01	09001	PARTIAL HOSPITALIZATION	341,505	119,751	461,256	0	461,256	90.01
91.00	09100	EMERGENCY	896,775	75,070	971,845	1,036,371	2,008,216	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS)						92.00
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	09850	OTHER REIMB COST CTR	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	574,173	462,198	1,036,371	-1,036,371	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	185,141	185,141	-185,141	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,902,879	18,002,503	34,905,382	-260,070	34,645,312	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	0	0	0	260,070	260,070	193.01
200.00		TOTAL (SUM OF LINES 118 through 199)	16,902,879	18,002,503	34,905,382	0	34,905,382	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0197

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

Worksheet A  
Date/Time Prepared:  
2/27/2019 3:19 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-15,754	854,170	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	408,081	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	16,802	2,700,713	4.00
5.01	00540	NONPATIENT TELEPHONES	-12,470	136,395	5.01
5.02	00550	DATA PROCESSING	0	543,915	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	247,962	5.03
5.04	00570	ADMITTING	0	390,055	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	527,567	5.05
5.06	00590	OTHER ADMINISTRATIVE & GENERAL	612,314	6,335,304	5.06
7.00	00700	OPERATION OF PLANT	-727	2,154,286	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	123,842	8.00
9.00	00900	HOUSEKEEPING	0	593,728	9.00
10.00	01000	DIETARY	-182,009	540,114	10.00
11.00	01100	CAFETERIA	0	161,242	11.00
13.00	01300	NURSING ADMINISTRATION	0	713,856	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	203,662	14.00
15.00	01500	PHARMACY	0	475,410	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-19,430	711,939	16.00
17.00	01700	SOCIAL SERVICE	0	171,667	17.00
18.00	01850	OTHER GEN SVC COST CTR	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
23.00	02300	PARAMED ED PROGRAM	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-139,996	6,197,224	30.00
31.00	03100	INTENSIVE CARE UNIT	-14,037	678,014	31.00
32.00	03200	CORONARY CARE UNIT	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	34.00
40.00	04000	SUBPROVIDER - I PF	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	1,381,767	50.00
51.00	05100	RECOVERY ROOM	0	218,484	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	-260,000	92,866	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-57,072	759,464	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	1,530,271	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	547,896	65.00
66.00	06600	PHYSICAL THERAPY	0	307,478	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	-100,125	161,867	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	419,593	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,702	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,680,922	73.00
74.00	07400	RENAL DIALYSIS	0	21,880	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION	0	461,256	90.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0197

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

Worksheet A  
Date/Time Prepared:  
2/27/2019 3:19 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
91.00	09100	EMERGENCY	-1,130,973	877,243	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	97.00
98.00	09850	OTHER REIMB COST CTR	0	0	98.00
99.00	09900	CMHC	0	0	99.00
99.10	09910	CORF	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
105.00	10500	KIDNEY ACQUISITION	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	115.00
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,303,477	33,341,835	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	MARKETING	0	260,070	193.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,303,477	33,601,905	200.00

		Increases				
		Cost Center	Line #	Salary	Other	
		2.00	3.00	4.00	5.00	
<b>A - RECLASSIFY INTEREST EXPENSE</b>						
1.00	CAP REL COSTS-MVBLE EQUIP		2.00	0	231	1.00
2.00	OTHER ADMINISTRATIVE & GENERAL		5.06	0	184,910	2.00
	O			0	185,141	
<b>B - RECLASSIFY ER PHYSICIANS &amp; EXPENSES</b>						
1.00	EMERGENCY		91.00	574,173	462,198	1.00
	O			574,173	462,198	
<b>C - RECLASSIFY CORPORATE COSTS</b>						
1.00	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	663,203	1.00
2.00	OTHER ADMINISTRATIVE & GENERAL		5.06	778,787	0	2.00
	O			778,787	663,203	
<b>D - RECLASSIFY MARKETING WAGES &amp; EXPENSE</b>						
1.00	MARKETING		193.01	240,801	19,269	1.00
	O			240,801	19,269	
<b>E - RECLASSIFY EMPLOYEE MEAL COSTS</b>						
1.00	CAFETERIA		11.00	38,140	56,829	1.00
	O			38,140	56,829	
<b>F - RECLASSIFY PROP/AUTO/WCOMP INS</b>						
1.00	CAP REL COSTS-BLDG & FIXT		1.00	0	205,639	1.00
2.00	CAP REL COSTS-MVBLE EQUIP		2.00	0	34,168	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	35,693	3.00
	O			0	275,500	
<b>G - RECLASSIFY IMPLANTABLE DEVICES</b>						
1.00	IMPL. DEV. CHARGED TO PATIENTS		72.00	0	11,702	1.00
	O			0	11,702	
<b>H - RECLASSIFY TELEMETRY/ICU SHARED COST</b>						
1.00	INTENSIVE CARE UNIT		31.00	633,815	40,236	1.00
	O			633,815	40,236	
500.00	Grand Total: Increases			2,265,716	1,714,078	500.00

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - RECLASSIFY INTEREST EXPENSE</b>							
1.00	INTEREST EXPENSE	113.00	0	185,141	11		1.00
2.00		0.00	0	0	0		2.00
	0		0	185,141			
<b>B - RECLASSIFY ER PHYSICIANS &amp; EXPENSES</b>							
1.00	I&R SERVICES-NOT APPRVD PRGM	100.00	574,173	462,198	0		1.00
	0		574,173	462,198			
<b>C - RECLASSIFY CORPORATE COSTS</b>							
1.00	OTHER ADMINISTRATIVE & GENERAL	5.06	0	1,441,990	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	1,441,990			
<b>D - RECLASSIFY MARKETING WAGES &amp; EXPENSE</b>							
1.00	OTHER ADMINISTRATIVE & GENERAL	5.06	240,801	19,269	0		1.00
	0		240,801	19,269			
<b>E - RECLASSIFY EMPLOYEE MEAL COSTS</b>							
1.00	DIETARY	10.00	38,140	56,829	0		1.00
	0		38,140	56,829			
<b>F - RECLASSIFY PROP/AUTO/WCOMP INS</b>							
1.00	OTHER ADMINISTRATIVE & GENERAL	5.06	0	275,500	12		1.00
2.00		0.00	0	0	12		2.00
3.00		0.00	0	0	0		3.00
	0		0	275,500			
<b>G - RECLASSIFY IMPLANTABLE DEVICES</b>							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	11,702	0		1.00
	0		0	11,702			
<b>H - RECLASSIFY TELEMETRY/ICU SHARED COST</b>							
1.00	ADULTS & PEDIATRICS	30.00	633,815	40,236	0		1.00
	0		633,815	40,236			
500.00	Grand Total: Decreases		1,486,929	2,492,865			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0197

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
2/27/2019 3:19 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	1,217,987	0	0	0	1.00
2.00	Land Improvements	1,175,795	47,496	0	47,496	2.00
3.00	Buildings and Fixtures	26,878,512	65,522	0	65,522	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	10,218,444	34,027	0	34,027	5.00
6.00	Movable Equipment	12,787,467	53,547	0	53,547	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	52,278,205	200,592	0	200,592	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	52,278,205	200,592	0	200,592	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	1,217,987	0			1.00
2.00	Land Improvements	1,223,291	27,147			2.00
3.00	Buildings and Fixtures	27,042,089	15,571,968			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	10,252,471	6,711,466			5.00
6.00	Movable Equipment	12,841,014	8,688,426			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	52,576,852	30,999,007			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	52,576,852	30,999,007			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0197

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
2/27/2019 3:19 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	664,285	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	373,682	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,037,967	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	664,285				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	373,682				2.00
3.00	Total (sum of lines 1-2)	0	1,037,967				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0197

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
2/27/2019 3:19 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	39,735,837	0	39,735,837	0.757857	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	12,841,014	145,000	12,696,014	0.242143	0	2.00
3.00	Total (sum of lines 1-2)	52,576,851	145,000	52,431,851	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	664,285	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	373,682	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,037,967	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	-15,754	205,639	0	0	854,170	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	231	34,168	0	0	408,081	2.00
3.00	Total (sum of lines 1-2)	-15,523	239,807	0	0	1,262,251	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-15,754	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)	B	51	OTHER ADMINISTRATIVE & GENERAL	5.06	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	-12,470	NONPATIENT TELEPHONES	5.01	0	7.00
8.00 Television and radio service (chapter 21)		0		0.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-1,702,203			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	520,236			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-90,321	DIETARY	10.00	0	14.00
15.00 Rental of quarters to employees and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients		0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-9,715	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines		0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	UTILIZATION REVIEW-SNF	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	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center		Line #	Wkst. A-7 Ref.
			1.00	2.00	3.00	4.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0 32.00
33.00 PASTORAL CARE	A	-368		OTHER ADMINISTRATIVE & GENERAL	5.06	0 33.00
33.01 MAINTENANCE MISC REVENUE	B	-723		OPERATION OF PLANT	7.00	0 33.01
33.02 ADJUST TRANSFER OF HOME DIETARY COST	A	-91,688		DIETARY	10.00	0 33.02
33.03 REMOVE UNREIMBURSABLE LIQUOR EXPENSE	A	-575		OTHER ADMINISTRATIVE & GENERAL	5.06	0 33.03
33.04 MCHC LOBBYING	A	-8,802		OTHER ADMINISTRATIVE & GENERAL	5.06	0 33.04
33.05 MARKETING/ADVERTISING	A			NURSING ADMINISTRATION	13.00	0 33.05
33.06 MARKETING/ADVERTISING	A	-4		OPERATION OF PLANT	7.00	0 33.06
33.07 MARKETING/ADVERTISING	A			OTHER ADMINISTRATIVE & GENERAL	5.06	0 33.07
33.08 ADMIN MISC REVENUE	B	118,574		OTHER ADMINISTRATIVE & GENERAL	5.06	0 33.08
33.09 HEALTH INFO MGMT REVENUE	B	-9,715		MEDICAL RECORDS & LIBRARY	16.00	0 33.09
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,303,477				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS  
 Provider CCN: 14-0197  
 Period: From 10/01/2017 To 09/30/2018  
 Worksheet A-8-1  
 Date/Time Prepared: 2/27/2019 3:19 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5
1.00	2.00	3.00	4.00	5.00
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	16,802	0
2.00	5.00	OTHER ADMINISTRATIVE & GENERAL	503,434	0
3.00	0.00	CORPORATE FINANCE BENEFITS	0	0
4.00	0.00	CORPORATE FINANCE SALARIES &	0	0
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.		520,236	0

\* 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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	G	BETHANT SH. SR.	100.00	BETHANY METH CO	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-0197	Period: From 10/01/2017 To 09/30/2018	Worksheet A-8-1 Date/Time Prepared: 2/27/2019 3:19 pm
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	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	16,802	0		1.00
2.00	503,434	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	520,236			5.00

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

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

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

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

6.00	HOSPITAL		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0197

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

Worksheet A-8-2

Date/Time Prepared:  
2/27/2019 3:19 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	139,996	139,996	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	14,037	14,037	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	260,000	260,000	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	57,072	57,072	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	100,125	100,125	0	0	0	7.00
8.00	90.01	PARTIAL HOSPITALIZATION	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	1,130,973	1,130,973	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,702,203	1,702,203	0	0	0	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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	7.00
8.00	90.01	PARTIAL HOSPITALIZATION	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	139,996		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	14,037		2.00
3.00	50.00	OPERATING ROOM	0	0	0	0		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	260,000		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	57,072		5.00
6.00	60.00	LABORATORY	0	0	0	0		6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	100,125		7.00
8.00	90.01	PARTIAL HOSPITALIZATION	0	0	0	0		8.00
9.00	91.00	EMERGENCY	0	0	0	1,130,973		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,702,203		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0197

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

Worksheet B  
Part I  
Date/Time Prepared:  
2/27/2019 3:19 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	854,170	854,170			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	408,081		408,081		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,700,713	8,802	221	2,709,736	4.00
5.01 00540	NONPATIENT TELEPHONES	136,395	4,738	237	4,974	146,344 5.01
5.02 00550	DATA PROCESSING	543,915	4,386	41,986	40,704	3,569 5.02
5.03 00560	PURCHASING RECEIVING AND STORES	247,962	10,269	534	42,589	5,354 5.03
5.04 00570	ADMITTING	390,055	5,853	107,039	41,643	2,677 5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	527,567	8,266	77	7,711	8,923 5.05
5.06 00590	OTHER ADMINISTRATIVE & GENERAL	6,335,304	102,607	7,018	209,638	25,878 5.06
7.00 00700	OPERATION OF PLANT	2,154,286	105,974	6,940	146,733	8,031 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	123,842	1,951	0	0	892 8.00
9.00 00900	HOUSEKEEPING	593,728	11,435	145,184	74,380	1,785 9.00
10.00 01000	DIETARY	540,114	55,803	1,490	111,089	7,139 10.00
11.00 01100	CAFETERIA	161,242	18,638	83	14,762	5,354 11.00
13.00 01300	NURSING ADMINISTRATION	713,856	3,257	931	97,891	7,139 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	203,662	25,085	44,891	11,760	1,785 14.00
15.00 01500	PHARMACY	475,410	7,122	0	61,307	2,677 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	711,939	12,550	166	87,901	8,031 16.00
17.00 01700	SOCIAL SERVICE	171,667	8,948	172	23,220	4,462 17.00
18.00 01850	OTHER GEN SVC COST CTR	0	0	0	0	0 18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	0 20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0 22.00
23.00 02300	PARAMED ED PROGRAM	0	0	0	0	0 23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	6,197,224	301,528	7,578	783,262	11,600 30.00
31.00 03100	INTENSIVE CARE UNIT	678,014	12,946	84	98,191	1,785 31.00
32.00 03200	CORONARY CARE UNIT	0	0	0	0	0 32.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0 33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0 34.00
40.00 04000	SUBPROVIDER - I/PF	0	0	0	0	0 40.00
41.00 04100	SUBPROVIDER - I/RF	0	0	0	0	0 41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0 42.00
43.00 04300	NURSERY	0	0	0	0	0 43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
45.00 04500	NURSING FACILITY	0	0	0	0	0 45.00
46.00 04600	OTHER LONG TERM CARE	0	0	0	0	0 46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	1,381,767	57,798	12,237	188,040	4,462 50.00
51.00 05100	RECOVERY ROOM	218,484	0	0	31,375	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00 05300	ANESTHESIOLOGY	92,866	0	712	13,083	1,785 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	759,464	26,596	23,477	75,672	9,816 54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0 55.00
56.00 05600	RADIOISOTOPE	0	0	0	0	0 56.00
57.00 05700	CT SCAN	0	0	0	0	0 57.00
58.00 05800	MRI	0	0	0	0	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000	LABORATORY	1,530,271	12,359	1,261	119,886	8,923 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0 60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0 61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0 62.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0 63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	547,896	6,176	1,923	69,182	3,569 65.00
66.00 06600	PHYSICAL THERAPY	307,478	9,095	187	25,531	1,785 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00 06900	ELECTROCARDIOLOGY	161,867	6,697	1,544	11,122	892 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	419,593	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	11,702	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,680,922	0	0	0	0 73.00
74.00 07400	RENAL DIALYSIS	21,880	0	0	0	0 74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0 75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0197

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

Worksheet B  
Part I  
Date/Time Prepared:  
2/27/2019 3:19 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.01 09001 PARTIAL HOSPITALIZATION	461,256	8,002	415	52,906	0	90.01
91.00 09100 EMERGENCY	877,243	15,675	1,694	227,879	8,031	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00 09850 OTHER REIMB COST CTR	0	0	0	0	0	98.00
99.00 09900 CMHC	0	0	0	0	0	99.00
99.10 09910 CORF	0	0	0	0	0	99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00 10600 HEART ACQUISITION	0	0	0	0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00 11600 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	33,341,835	852,556	408,081	2,672,431	146,344	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,614	0	0	0	190.00
191.00 19100 RESEARCH	0	0	0	0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
193.01 19301 MARKETING	260,070	0	0	37,305	0	193.01
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	33,601,905	854,170	408,081	2,709,736	146,344	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 14-0197		Period: From 10/01/2017 To 09/30/2018		Worksheet B Part I Date/Time Prepared: 2/27/2019 3:19 pm	
Cost Center Description			DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMINISTRATIVE	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	634,560					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	21,642	328,350				5.03
5.04	00570	ADMINISTRATIVE	63,379	504	611,150			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	66,470	115	0	619,129		5.05
5.06	00590	OTHER ADMINISTRATIVE & GENERAL	244,240	3,286	0	0	6,927,971	5.06
7.00	00700	OPERATION OF PLANT	0	7,556	0	0	2,429,520	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	126,685	8.00
9.00	00900	HOUSEKEEPING	0	5,942	0	0	832,454	9.00
10.00	01000	DIETARY	0	56,671	0	0	772,306	10.00
11.00	01100	CAFETERIA	0	589	0	0	200,668	11.00
13.00	01300	NURSING ADMINISTRATION	64,925	808	0	0	888,807	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	9,435	0	0	296,618	14.00
15.00	01500	PHARMACY	33,235	211	0	0	579,962	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	40,191	828	0	0	861,606	16.00
17.00	01700	SOCIAL SERVICE	0	381	0	0	208,850	17.00
18.00	01850	OTHER GEN SVC COST CTR	0	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PROGRAM	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	0	11,082	277,800	198,035	7,788,109	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	8,397	5,825	805,242	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	3,180	8,516	47,948	1,703,948	50.00
51.00	05100	RECOVERY ROOM	0	17	1,296	10,506	261,678	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	61	1,504	10,257	120,268	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,733	4,527	20,808	26,613	971,706	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	75,745	23,021	76,153	91,353	1,938,972	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	4,624	49,838	38,715	721,923	65.00
66.00	06600	PHYSICAL THERAPY	0	135	1,451	9,761	355,423	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	39	13,096	13,583	208,840	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	38,361	23,407	29,072	510,433	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	213	211	12,126	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	149,502	97,449	77,569	2,005,442	73.00
74.00	07400	RENAL DIALYSIS	0	0	342	237	22,459	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION	0	3,157	25	15,658	541,419	90.01
91.00	09100	EMERGENCY	0	4,318	30,855	43,786	1,209,481	91.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0197

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

Worksheet B  
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Cost Center Description			DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMINISTRATIVE	CASHIERING/AC COUNTS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS)					0	92.00
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	09850	OTHER REIMB COST CTR	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	634,560	328,350	611,150	619,129	33,302,916	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	1,614	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	0	0	0	0	297,375	193.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	634,560	328,350	611,150	619,129	33,601,905	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0197

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

Worksheet B  
Part I  
Date/Time Prepared:  
2/27/2019 3:19 pm

Cost Center Description		OTHER ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.06	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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	6,927,971					5.06
7.00	00700	631,014	3,060,534				7.00
8.00	00800	32,904	9,898	169,487			8.00
9.00	00900	216,212	58,012	555	1,107,233		9.00
10.00	01000	200,589	283,102	0	34,594	1,290,591	10.00
11.00	01100	52,119	94,553	555	2,320	0	11.00
13.00	01300	230,848	16,522	0	17,485	0	13.00
14.00	01400	77,040	127,262	0	20,037	0	14.00
15.00	01500	150,632	36,132	0	0	0	15.00
16.00	01600	223,783	63,668	555	8,003	0	16.00
17.00	01700	54,244	45,397	0	0	0	17.00
18.00	01850	0	0	0	0	0	18.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	2,022,795	1,529,709	117,488	564,172	1,230,119	30.00
31.00	03100	209,144	65,677	9,874	39,784	60,472	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
34.00	03400	0	0	0	0	0	34.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	442,563	293,223	10,572	192,484	0	50.00
51.00	05100	67,965	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	31,237	0	0	0	0	53.00
54.00	05400	252,379	134,927	6,682	49,121	0	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	503,605	62,701	0	58,952	0	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	187,504	31,332	555	15,717	0	65.00
66.00	06600	92,313	46,142	4,936	18,239	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	54,242	33,974	11,251	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	132,574	0	0	0	0	71.00
72.00	07200	3,149	0	0	0	0	72.00
73.00	07300	520,869	0	0	0	0	73.00
74.00	07400	5,833	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
90.01	09001	140,622	40,597	6,464	79,018	0	90.01
91.00	09100	314,136	79,520	0	0	0	91.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0197

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

Worksheet B  
Part I  
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Cost Center Description			OTHER ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	7.00	8.00	9.00	10.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	09850	OTHER REIMB COST CTR	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,850,315	3,052,348	169,487	1,099,926	1,290,591	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	419	8,186	0	7,307	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	77,237	0	0	0	0	193.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,927,971	3,060,534	169,487	1,107,233	1,290,591	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0197

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

Worksheet B  
Part I  
Date/Time Prepared:  
2/27/2019 3:19 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	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	350,215					11.00
13.00	01300	8,283	1,161,945				13.00
14.00	01400	2,579	8,277	531,813			14.00
15.00	01500	6,174	43,480	0	816,380		15.00
16.00	01600	12,829	55,308	0	0	1,225,752	16.00
17.00	01700	2,961	6,650	0	0	0	17.00
18.00	01850	0	0	0	0	0	18.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	153,712	603,232	3,591	0	392,032	30.00
31.00	03100	21,058	0	0	0	11,532	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
34.00	03400	0	0	0	0	0	34.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	47,241	123,745	1,090	0	94,931	50.00
51.00	05100	7,704	21,568	0	0	20,800	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	579	10,194	0	0	20,307	53.00
54.00	05400	15,321	43,381	0	0	52,692	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	18,424	69,607	0	0	180,869	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	8,994	42,090	0	0	76,650	65.00
66.00	06600	2,524	19,537	0	0	19,325	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	1,464	7,947	0	0	26,893	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	526,803	0	57,560	71.00
72.00	07200	0	0	0	0	419	72.00
73.00	07300	0	0	0	816,380	153,579	73.00
74.00	07400	0	0	0	0	470	74.00
75.00	07500	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
90.01	09001	7,420	30,751	0	0	31,001	90.01
91.00	09100	29,254	76,178	329	0	86,692	91.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0197

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

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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	09850 OTHER REIMB COST CTR	0	0	0	0	0	98.00
99.00	09900 CMHC	0	0	0	0	0	99.00
99.10	09910 CORF	0	0	0	0	0	99.10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
105.00	10500 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600 HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300 INTEREST EXPENSE						113.00
114.00	11400 UTILIZATION REVIEW-SNF						114.00
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600 HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	346,521	1,161,945	531,813	816,380	1,225,752	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100 RESEARCH	0	0	0	0	0	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300 NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301 MARKETING	3,694	0	0	0	0	193.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	350,215	1,161,945	531,813	816,380	1,225,752	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0197

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

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Part I  
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Cost Center Description	SOCIAL SERVICE	OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS	
		OTHER GEN SVC COST CTR			SERVICES-SALARY & FRINGES APPRV	
	17.00	18.00	19.00	20.00	21.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 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 & 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
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 01500 PHARMACY						15.00
16.00 01600 MEDICAL RECORDS & LIBRARY						16.00
17.00 01700 SOCIAL SERVICE	318,102					17.00
18.00 01850 OTHER GEN SVC COST CTR	0	0				18.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00 02000 NURSING SCHOOL	0	0		0		20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00 02300 PARAMED ED PROGRAM	0	0				23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	303,197	0	0	0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	14,905	0	0	0	0	31.00
32.00 03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00 04000 SUBPROVIDER - 1PF	0	0	0	0	0	40.00
41.00 04100 SUBPROVIDER - 1RF	0	0	0	0	0	41.00
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300 NURSERY	0	0	0	0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00 04500 NURSING FACILITY	0	0	0	0	0	45.00
46.00 04600 OTHER LONG TERM CARE	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MRI	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	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
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000 CLINIC	0	0	0	0	0	90.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0197

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

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Cost Center Description	SOCIAL SERVICE	OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS	
		OTHER GEN SVC COST CTR			SERVICES-SALARY & FRINGES APPRV	
	17.00	18.00	19.00	20.00	21.00	
90.01 09001 PARTIAL HOSPITALIZATION	0	0	0	0	0	90.01
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00 09850 OTHER REIMB COST CTR	0	0	0	0	0	98.00
99.00 09900 CMHC	0	0	0	0	0	99.00
99.10 09910 CORF	0	0	0	0	0	99.10
100.00 10000 I & R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00 10600 HEART ACQUISITION	0	0	0	0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00 11600 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	318,102	0	0	0	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100 RESEARCH	0	0	0	0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
193.01 19301 MARKETING	0	0	0	0	0	193.01
200.00 Cross Foot Adjustments			0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	318,102	0	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0197

Period:  
From 10/01/2017  
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Cost Center Description		INTERNS & RESIDENTS	PARAMED PROGRAM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		SERVICES-OTHER PRGM COSTS APPRV					
		22.00	23.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	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 & 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
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
18.00	01850	OTHER GEN SVC COST CTR					18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
20.00	02000	NURSING SCHOOL					20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0				22.00
23.00	02300	PARAMED PROGRAM		0			23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	0	14,708,156	0	14,708,156
31.00	03100	INTENSIVE CARE UNIT	0	0	1,237,688	0	1,237,688
32.00	03200	CORONARY CARE UNIT	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	2,909,797	0	2,909,797
51.00	05100	RECOVERY ROOM	0	0	379,715	0	379,715
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	182,585	0	182,585
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	1,526,209	0	1,526,209
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	2,833,130	0	2,833,130
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,084,765	0	1,084,765
66.00	06600	PHYSICAL THERAPY	0	0	558,439	0	558,439
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	344,611	0	344,611
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,227,370	0	1,227,370
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	15,694	0	15,694
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,496,270	0	3,496,270
74.00	07400	RENAL DIALYSIS	0	0	28,762	0	28,762
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00

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COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0197

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

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Cost Center Description	INTERNS & RESIDENTS	PARAMED PROGRAM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	SERVICES-OTHER PRGM COSTS APPRV					
	22.00					
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.01 09001 PARTIAL HOSPITALIZATION	0	0	877,292	0	877,292	90.01
91.00 09100 EMERGENCY	0	0	1,795,590	0	1,795,590	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00 09850 OTHER REIMB COST CTR	0	0	0	0	0	98.00
99.00 09900 CMHC	0	0	0	0	0	99.00
99.10 09910 CORF	0	0	0	0	0	99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00 10600 HEART ACQUISITION	0	0	0	0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 11300 INTEREST EXPENSE	0	0	0	0	0	113.00
114.00 11400 UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00 11600 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	33,206,073	0	33,206,073	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	17,526	0	17,526	190.00
191.00 19100 RESEARCH	0	0	0	0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
193.01 19301 MARKETING	0	0	378,306	0	378,306	193.01
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)	0	0	33,601,905	0	33,601,905	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0197

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

Worksheet B  
Part II  
Date/Time Prepared:  
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Cost Center Description		CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT		
		Directly Assigned New Capital Related Costs	BLDG & FIXT				MVBLE EQUIP
		0	1.00				2.00
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	8,802	221	9,023	
5.01	00540	NONPATIENT TELEPHONES	0	4,738	237	4,975	
5.02	00550	DATA PROCESSING	0	4,386	41,986	46,372	
5.03	00560	PURCHASING RECEIVING AND STORES	0	10,269	534	10,803	
5.04	00570	ADMINISTRATIVE	0	5,853	107,039	112,892	
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	8,266	77	8,343	
5.06	00590	OTHER ADMINISTRATIVE & GENERAL	2,034	102,607	7,018	111,659	
7.00	00700	OPERATION OF PLANT	0	105,974	6,940	112,914	
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,951	0	1,951	
9.00	00900	HOUSEKEEPING	0	11,435	145,184	156,619	
10.00	01000	DIETARY	0	55,803	1,490	57,293	
11.00	01100	CAFETERIA	0	18,638	83	18,721	
13.00	01300	NURSING ADMINISTRATION	0	3,257	931	4,188	
14.00	01400	CENTRAL SERVICES & SUPPLY	0	25,085	44,891	69,976	
15.00	01500	PHARMACY	9,547	7,122	0	16,669	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,550	166	12,716	
17.00	01700	SOCIAL SERVICE	0	8,948	172	9,120	
18.00	01850	OTHER GEN SVC COST CTR	0	0	0	0	
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	
20.00	02000	NURSING SCHOOL	0	0	0	0	
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	
23.00	02300	PARAMED ED PROGRAM	0	0	0	0	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	301,528	7,578	309,106	
31.00	03100	INTENSIVE CARE UNIT	0	12,946	84	13,030	
32.00	03200	CORONARY CARE UNIT	0	0	0	0	
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	
42.00	04200	SUBPROVIDER	0	0	0	0	
43.00	04300	NURSERY	0	0	0	0	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	
45.00	04500	NURSING FACILITY	0	0	0	0	
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	57,798	12,237	70,035	
51.00	05100	RECOVERY ROOM	0	0	0	0	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	
53.00	05300	ANESTHESIOLOGY	1,166	0	712	1,878	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	26,596	23,477	50,073	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	
56.00	05600	RADIOISOTOPE	0	0	0	0	
57.00	05700	CT SCAN	0	0	0	0	
58.00	05800	MRI	0	0	0	0	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	
60.00	06000	LABORATORY	0	12,359	1,261	13,620	
60.01	06001	BLOOD LABORATORY	0	0	0	0	
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	
65.00	06500	RESPIRATORY THERAPY	13,614	6,176	1,923	21,713	
66.00	06600	PHYSICAL THERAPY	0	9,095	187	9,282	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	
69.00	06900	ELECTROCARDIOLOGY	0	6,697	1,544	8,241	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	
74.00	07400	RENAL DIALYSIS	0	0	0	0	
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0197

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

Worksheet B  
Part II  
Date/Time Prepared:  
2/27/2019 3:19 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
	0	1.00	2.00	2A	4.00	
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.01 09001 PARTIAL HOSPITALIZATION	0	8,002	415	8,417	176	90.01
91.00 09100 EMERGENCY	0	15,675	1,694	17,369	759	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00 09850 OTHER REIMB COST CTR	0	0	0	0	0	98.00
99.00 09900 CMHC	0	0	0	0	0	99.00
99.10 09910 CORF	0	0	0	0	0	99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00 10600 HEART ACQUISITION	0	0	0	0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00 11600 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	26,361	852,556	408,081	1,286,998	8,899	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,614	0	1,614	0	190.00
191.00 19100 RESEARCH	0	0	0	0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
193.01 19301 MARKETING	0	0	0	0	124	193.01
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	26,361	854,170	408,081	1,288,612	9,023	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0197		Period: From 10/01/2017 To 09/30/2018		Worksheet B Part II Date/Time Prepared: 2/27/2019 3:19 pm	
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	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	4,992					5.01
5.02	00550	DATA PROCESSING	122	46,630				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	183	1,590	12,718			5.03
5.04	00570	ADMINISTRATIVE	91	4,657	20	117,799		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	304	4,885	4	0	13,562	5.05
5.06	00590	OTHER ADMINISTRATIVE & GENERAL	882	17,949	127	0	0	5.06
7.00	00700	OPERATION OF PLANT	274	0	293	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	30	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	61	0	230	0	0	9.00
10.00	01000	DIETARY	244	0	2,195	0	0	10.00
11.00	01100	CAFETERIA	183	0	23	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	244	4,771	31	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	61	0	365	0	0	14.00
15.00	01500	PHARMACY	91	2,442	8	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	274	2,953	32	0	0	16.00
17.00	01700	SOCIAL SERVICE	152	0	15	0	0	17.00
18.00	01850	OTHER GEN SVC COST CTR	0	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PROGRAM	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	396	0	429	53,553	4,327	30.00
31.00	03100	INTENSIVE CARE UNIT	61	0	0	1,618	128	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	152	0	123	1,641	1,052	50.00
51.00	05100	RECOVERY ROOM	0	0	1	250	230	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	61	0	2	290	225	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	335	1,817	175	4,010	584	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	304	5,566	892	14,677	2,003	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	122	0	179	9,605	849	65.00
66.00	06600	PHYSICAL THERAPY	61	0	5	280	214	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	30	0	2	2,524	298	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,486	4,511	638	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	41	5	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	5,792	18,781	1,701	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	66	5	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION	0	0	122	5	343	90.01
91.00	09100	EMERGENCY	274	0	167	5,947	960	91.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0197

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

Worksheet B  
Part II  
Date/Time Prepared:  
2/27/2019 3:19 pm

Cost Center Description		NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMINISTRATIVE	CASHIERING/AC COUNTS RECEIVABLE	
		5.01	5.02	5.03	5.04	5.05	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS)						92.00
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	09850 OTHER REIMB COST CTR	0	0	0	0	0	98.00
99.00	09900 CMHC	0	0	0	0	0	99.00
99.10	09910 CORF	0	0	0	0	0	99.10
100.00	10000 I & R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
105.00	10500 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600 HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300 INTEREST EXPENSE						113.00
114.00	11400 UTILIZATION REVIEW-SNF						114.00
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600 HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	4,992	46,630	12,718	117,799	13,562	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100 RESEARCH	0	0	0	0	0	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300 NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301 MARKETING	0	0	0	0	0	193.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	4,992	46,630	12,718	117,799	13,562	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0197

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

Worksheet B  
Part II  
Date/Time Prepared:  
2/27/2019 3:19 pm

Cost Center Description		OTHER ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.06	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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	131,315					5.06
7.00	00700	11,961	125,931				7.00
8.00	00800	624	407	3,012			8.00
9.00	00900	4,098	2,387	10	163,653		9.00
10.00	01000	3,802	11,649	0	5,113	80,666	10.00
11.00	01100	988	3,891	10	343	0	11.00
13.00	01300	4,376	680	0	2,584	0	13.00
14.00	01400	1,460	5,236	0	2,962	0	14.00
15.00	01500	2,855	1,487	0	0	0	15.00
16.00	01600	4,242	2,620	10	1,183	0	16.00
17.00	01700	1,028	1,868	0	0	0	17.00
18.00	01850	0	0	0	0	0	18.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	38,338	62,942	2,087	83,387	76,886	30.00
31.00	03100	3,964	2,702	175	5,880	3,780	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
34.00	03400	0	0	0	0	0	34.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	8,389	12,065	188	28,450	0	50.00
51.00	05100	1,288	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	592	0	0	0	0	53.00
54.00	05400	4,784	5,552	119	7,260	0	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	9,546	2,580	0	8,713	0	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	3,554	1,289	10	2,323	0	65.00
66.00	06600	1,750	1,899	88	2,696	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	1,028	1,398	200	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	2,513	0	0	0	0	71.00
72.00	07200	60	0	0	0	0	72.00
73.00	07300	9,873	0	0	0	0	73.00
74.00	07400	111	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
90.01	09001	2,665	1,670	115	11,679	0	90.01
91.00	09100	5,954	3,272	0	0	0	91.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0197

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

Worksheet B  
Part II  
Date/Time Prepared:  
2/27/2019 3:19 pm

Cost Center Description		OTHER ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	09850 OTHER REIMB COST CTR	0	0	0	0	0	98.00
99.00	09900 CMHC	0	0	0	0	0	99.00
99.10	09910 CORF	0	0	0	0	0	99.10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
105.00	10500 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600 HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300 INTEREST EXPENSE						113.00
114.00	11400 UTILIZATION REVIEW-SNF						114.00
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600 HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	129,843	125,594	3,012	162,573	80,666	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	8	337	0	1,080	0	190.00
191.00	19100 RESEARCH	0	0	0	0	0	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300 NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301 MARKETING	1,464	0	0	0	0	193.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	131,315	125,931	3,012	163,653	80,666	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0197		Period: From 10/01/2017 To 09/30/2018		Worksheet B Part II Date/Time Prepared: 2/27/2019 3:19 pm	
Cost Center Description			CAFETERIA	NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	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 & 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	24,208					11.00
13.00	01300	NURSING ADMINISTRATION	573	17,773				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	178	127	80,404			14.00
15.00	01500	PHARMACY	427	665	0	24,848		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	887	846	0	0	26,056	16.00
17.00	01700	SOCIAL SERVICE	205	102	0	0	0	17.00
18.00	01850	OTHER GEN SVC COST CTR	0	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PROGRAM	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	10,624	9,228	543	0	8,322	30.00
31.00	03100	INTENSIVE CARE UNIT	1,456	0	0	0	245	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00	04000	SUBPROVIDER - I/PF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - I/RF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	3,265	1,892	165	0	2,019	50.00
51.00	05100	RECOVERY ROOM	533	330	0	0	442	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	40	156	0	0	432	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,059	663	0	0	1,121	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,274	1,064	0	0	3,848	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	622	644	0	0	1,631	65.00
66.00	06600	PHYSICAL THERAPY	174	299	0	0	411	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	101	122	0	0	572	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	79,646	0	1,224	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	9	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	24,848	3,267	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	10	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION	513	470	0	0	659	90.01
91.00	09100	EMERGENCY	2,022	1,165	50	0	1,844	91.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0197

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

Worksheet B  
Part II  
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	09850	OTHER REIMB COST CTR	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,953	17,773	80,404	24,848	26,056	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	255	0	0	0	0	193.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	24,208	17,773	80,404	24,848	26,056	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0197

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

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Part II  
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Cost Center Description	SOCIAL SERVICE	OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS	
		OTHER GEN SVC COST CTR			SERVICES-SALARY & FRINGES APPRV	
	17.00	18.00	19.00	20.00	21.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 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 & 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
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 01500 PHARMACY						15.00
16.00 01600 MEDICAL RECORDS & LIBRARY						16.00
17.00 01700 SOCIAL SERVICE	12,567					17.00
18.00 01850 OTHER GEN SVC COST CTR	0	0				18.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00 02000 NURSING SCHOOL	0	0		0		20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00 02300 PARAMED ED PROGRAM	0	0				23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	11,978	0				30.00
31.00 03100 INTENSIVE CARE UNIT	589	0				31.00
32.00 03200 CORONARY CARE UNIT	0	0				32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0				33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0				34.00
40.00 04000 SUBPROVIDER - 1PF	0	0				40.00
41.00 04100 SUBPROVIDER - 1RF	0	0				41.00
42.00 04200 SUBPROVIDER	0	0				42.00
43.00 04300 NURSERY	0	0				43.00
44.00 04400 SKILLED NURSING FACILITY	0	0				44.00
45.00 04500 NURSING FACILITY	0	0				45.00
46.00 04600 OTHER LONG TERM CARE	0	0				46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	0				50.00
51.00 05100 RECOVERY ROOM	0	0				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53.00 05300 ANESTHESIOLOGY	0	0				53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0				54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0				55.00
56.00 05600 RADIOISOTOPE	0	0				56.00
57.00 05700 CT SCAN	0	0				57.00
58.00 05800 MRI	0	0				58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0				59.00
60.00 06000 LABORATORY	0	0				60.00
60.01 06001 BLOOD LABORATORY	0	0				60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0				61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
64.00 06400 INTRAVENOUS THERAPY	0	0				64.00
65.00 06500 RESPIRATORY THERAPY	0	0				65.00
66.00 06600 PHYSICAL THERAPY	0	0				66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68.00
69.00 06900 ELECTROCARDIOLOGY	0	0				69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
74.00 07400 RENAL DIALYSIS	0	0				74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0				75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0	0				88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89.00
90.00 09000 CLINIC	0	0				90.00

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ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0197

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

Worksheet B  
Part II  
Date/Time Prepared:  
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Cost Center Description	SOCIAL SERVICE	OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS	
		OTHER GEN SVC COST CTR			SERVICES-SALARY & FRINGES APPRV	
	17.00	18.00	19.00	20.00	21.00	
90.01 09001 PARTIAL HOSPITALIZATION	0	0				90.01
91.00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
94.00 09400 HOME PROGRAM DIALYSIS	0	0				94.00
95.00 09500 AMBULANCE SERVICES	0	0				95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0				96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0				97.00
98.00 09850 OTHER REIMB COST CTR	0	0				98.00
99.00 09900 CMHC	0	0				99.00
99.10 09910 CORF	0	0				99.10
100.00 10000 I & R SERVICES-NOT APPRVD PRGM	0	0				100.00
101.00 10100 HOME HEALTH AGENCY	0	0				101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
105.00 10500 KIDNEY ACQUISITION	0	0				105.00
106.00 10600 HEART ACQUISITION	0	0				106.00
107.00 10700 LIVER ACQUISITION	0	0				107.00
108.00 10800 LUNG ACQUISITION	0	0				108.00
109.00 10900 PANCREAS ACQUISITION	0	0				109.00
110.00 11000 INTESTINAL ACQUISITION	0	0				110.00
111.00 11100 ISLET ACQUISITION	0	0				111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0				115.00
116.00 11600 HOSPICE	0	0				116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	12,567	0	0	0	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00
191.00 19100 RESEARCH	0	0				191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0				192.00
193.00 19300 NONPAID WORKERS	0	0				193.00
193.01 19301 MARKETING	0	0				193.01
200.00 Cross Foot Adjustments			0	0		200.00
201.00 Negative Cost Centers	0	0	0	0		201.00
202.00 TOTAL (sum lines 118 through 201)	12,567	0	0	0		202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0197	Period: From 10/01/2017 To 09/30/2018	Worksheet B Part II Date/Time Prepared: 2/27/2019 3:19 pm
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Cost Center Description	INTERNS & RESIDENTS	PARAMED PROGRAM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	SERVICES-OTHER PRGM COSTS APPRV					
	22.00	23.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 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 & 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
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE					17.00
18.00 01850	OTHER GEN SVC COST CTR					18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS					19.00
20.00 02000	NURSING SCHOOL					20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV					21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0				22.00
23.00 02300	PARAMED ED PROGRAM		0			23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS		674,752	0	674,752	30.00
31.00 03100	INTENSIVE CARE UNIT		33,955	0	33,955	31.00
32.00 03200	CORONARY CARE UNIT		0	0	0	32.00
33.00 03300	BURN INTENSIVE CARE UNIT		0	0	0	33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT		0	0	0	34.00
40.00 04000	SUBPROVIDER - IPF		0	0	0	40.00
41.00 04100	SUBPROVIDER - IRF		0	0	0	41.00
42.00 04200	SUBPROVIDER		0	0	0	42.00
43.00 04300	NURSERY		0	0	0	43.00
44.00 04400	SKILLED NURSING FACILITY		0	0	0	44.00
45.00 04500	NURSING FACILITY		0	0	0	45.00
46.00 04600	OTHER LONG TERM CARE		0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM		130,062	0	130,062	50.00
51.00 05100	RECOVERY ROOM		3,179	0	3,179	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM		0	0	0	52.00
53.00 05300	ANESTHESIOLOGY		3,720	0	3,720	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC		77,804	0	77,804	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC		0	0	0	55.00
56.00 05600	RADIOISOTOPE		0	0	0	56.00
57.00 05700	CT SCAN		0	0	0	57.00
58.00 05800	MRI		0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION		0	0	0	59.00
60.00 06000	LABORATORY		64,486	0	64,486	60.00
60.01 06001	BLOOD LABORATORY		0	0	0	60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY		0	0	0	61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	62.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.		0	0	0	63.00
64.00 06400	INTRAVENOUS THERAPY		0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY		42,771	0	42,771	65.00
66.00 06600	PHYSICAL THERAPY		17,244	0	17,244	66.00
67.00 06700	OCCUPATIONAL THERAPY		0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY		0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY		14,553	0	14,553	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY		0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT		90,018	0	90,018	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS		115	0	115	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS		64,262	0	64,262	73.00
74.00 07400	RENAL DIALYSIS		192	0	192	74.00
75.00 07500	ASC (NON-DISTINCT PART)		0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC		0	0	0	88.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0197

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

Worksheet B  
Part II  
Date/Time Prepared:  
2/27/2019 3:19 pm

Cost Center Description	INTERNS & RESIDENTS	PARAMED PROGRAM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	SERVICES-OTHER PRGM COSTS APPRV					
	22.00	23.00	24.00	25.00	26.00	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	89.00
90.00 09000 CLINIC			0	0	0	90.00
90.01 09001 PARTIAL HOSPITALIZATION			26,834	0	26,834	90.01
91.00 09100 EMERGENCY			39,783	0	39,783	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS			0	0	0	94.00
95.00 09500 AMBULANCE SERVICES			0	0	0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED			0	0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD			0	0	0	97.00
98.00 09850 OTHER REIMB COST CTR			0	0	0	98.00
99.00 09900 CMHC			0	0	0	99.00
99.10 09910 CORF			0	0	0	99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM			0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY			0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION			0	0	0	105.00
106.00 10600 HEART ACQUISITION			0	0	0	106.00
107.00 10700 LIVER ACQUISITION			0	0	0	107.00
108.00 10800 LUNG ACQUISITION			0	0	0	108.00
109.00 10900 PANCREAS ACQUISITION			0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION			0	0	0	110.00
111.00 11100 ISLET ACQUISITION			0	0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)			0	0	0	115.00
116.00 11600 HOSPICE			0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	1,283,730	0	1,283,730	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN			3,039	0	3,039	190.00
191.00 19100 RESEARCH			0	0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES			0	0	0	192.00
193.00 19300 NONPAID WORKERS			0	0	0	193.00
193.01 19301 MARKETING			1,843	0	1,843	193.01
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)	0	0	1,288,612	0	1,288,612	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0197

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

Worksheet B-1

Date/Time Prepared:  
2/27/2019 3:19 pm

Cost Center Description	CAPITAL RELATED COSTS					
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF TELEPHONES)	DATA PROCESSING (MACHINE TI ME)	
	1.00	2.00	4.00	5.01	5.02	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	116,454				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		2,189,000			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,200	1,185	17,491,142		4.00
5.01 00540	NONPATIENT TELEPHONES	646	1,272	32,109	164	5.01
5.02 00550	DATA PROCESSING	598	225,218	262,739	4	5.02
5.03 00560	PURCHASING RECEIVING AND STORES	1,400	2,867	274,910	6	5.03
5.04 00570	ADMITTING	798	574,173	268,803	3	5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	1,127	414	49,776	10	5.05
5.06 00590	OTHER ADMINISTRATIVE & GENERAL	13,989	37,645	1,353,203	29	5.06
7.00 00700	OPERATION OF PLANT	14,448	37,227	947,152	9	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	266	0	0	1	8.00
9.00 00900	HOUSEKEEPING	1,559	778,787	480,117	2	9.00
10.00 01000	DIETARY	7,608	7,990	717,074	8	10.00
11.00 01100	CAFETERIA	2,541	444	95,288	6	11.00
13.00 01300	NURSING ADMINISTRATION	444	4,994	631,881	8	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	3,420	240,801	75,909	2	14.00
15.00 01500	PHARMACY	971	0	395,731	3	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,711	888	567,398	9	16.00
17.00 01700	SOCIAL SERVICE	1,220	925	149,883	5	17.00
18.00 01850	OTHER GEN SVC COST CTR	0	0	0	0	18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00 02300	PARAMED ED PROGRAM	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	41,109	40,647	5,055,866	13	30.00
31.00 03100	INTENSIVE CARE UNIT	1,765	450	633,815	2	31.00
32.00 03200	CORONARY CARE UNIT	0	0	0	0	32.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
40.00 04000	SUBPROVIDER - I/PF	0	0	0	0	40.00
41.00 04100	SUBPROVIDER - I/RF	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
43.00 04300	NURSERY	0	0	0	0	43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00 04500	NURSING FACILITY	0	0	0	0	45.00
46.00 04600	OTHER LONG TERM CARE	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	7,880	65,641	1,213,787	5	50.00
51.00 05100	RECOVERY ROOM	0	0	202,526	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	3,819	84,452	2	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,626	125,934	488,456	11	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00 05600	RADIOISOTOPE	0	0	0	0	56.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MRI	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	1,685	6,764	773,857	10	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	842	10,314	446,566	4	65.00
66.00 06600	PHYSICAL THERAPY	1,240	1,001	164,801	2	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	913	8,284	71,789	1	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0197

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

Worksheet B-1  
Date/Time Prepared:  
2/27/2019 3:19 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF TELEPHONES)	DATA PROCESSING (MACHINE TIME)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5.01	5.02	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION	1,091	2,228	341,505	0	0	90.01
91.00	09100	EMERGENCY	2,137	9,088	1,470,948	9	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	09850	OTHER REIMB COST CTR	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	116,234	2,189,000	17,250,341	164	4,105	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	220	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	0	0	240,801	0	0	193.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	854,170	408,081	2,709,736	146,344	634,560	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.334827	0.186423	0.154920	892.341463	154.582217	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			9,023	4,992	46,630	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000516	30.439024	11.359318	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: 14-0197

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

Worksheet B-1

Date/Time Prepared:  
2/27/2019 3:19 pm

Cost Center Description		PURCHASING RECEIVING AND STORES (SUPPLIES EXPENSE)	ADMITTING (INPATIENT CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		5.03	5.04	5.05	5A.06	5.06	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	3,691,709				5.03
5.04	00570	ADMITTING	5,669	30,785,342			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,293	0	44,957,451		5.05
5.06	00590	OTHER ADMINISTRATIVE & GENERAL	36,944	0	0	-6,927,971	5.06
7.00	00700	OPERATION OF PLANT	84,952	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	66,806	0	0	0	9.00
10.00	01000	DIETARY	637,161	0	0	0	10.00
11.00	01100	CAFETERIA	6,618	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	9,084	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	106,076	0	0	0	14.00
15.00	01500	PHARMACY	2,370	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,305	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	4,285	0	0	0	17.00
18.00	01850	OTHER GEN SVC COST CTR	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PROGRAM	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	124,595	13,993,564	14,379,037	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	422,973	422,973	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	35,752	428,984	3,481,808	0	50.00
51.00	05100	RECOVERY ROOM	193	65,297	762,884	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	685	75,748	744,806	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	50,899	1,048,152	1,932,572	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	258,827	3,836,022	6,633,741	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	51,983	2,510,478	2,811,307	0	65.00
66.00	06600	PHYSICAL THERAPY	1,513	73,112	708,781	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	436	659,698	986,373	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	431,295	1,179,077	2,111,129	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,725	15,355	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,680,922	4,908,768	5,632,811	0	73.00
74.00	07400	RENAL DIALYSIS	0	17,241	17,241	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0197

Period:  
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Worksheet B-1

Date/Time Prepared:  
2/27/2019 3:19 pm

Cost Center Description			PURCHASING RECEIVING AND STORES (SUPPLIES EXPENSE)	ADMITTING (INPATIENT CHARGES)	CASHIERING/AC COUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
90.01	09001	PARTIAL HOSPITALIZATION	35,496	1,260	1,137,024	0	541,419	90.01
91.00	09100	EMERGENCY	48,550	1,554,243	3,179,609	0	1,209,481	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	09850	OTHER REIMB COST CTR	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,691,709	30,785,342	44,957,451	-6,927,971	26,374,945	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	1,614	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	0	0	0	0	297,375	193.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	328,350	611,150	619,129		6,927,971	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.088943	0.019852	0.013771		0.259728	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	12,718	117,799	13,562		131,315	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.003445	0.003826	0.000302		0.004923	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: 14-0197

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

Worksheet B-1

Date/Time Prepared:  
2/27/2019 3:19 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE)	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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	82,248					7.00
8.00	00800	266	432,749				8.00
9.00	00900	1,559	1,417	38,184			9.00
10.00	01000	7,608	0	1,193	54,870		10.00
11.00	01100	2,541	1,417	80	0	32,048	11.00
13.00	01300	444	0	603	0	758	13.00
14.00	01400	3,420	0	691	0	236	14.00
15.00	01500	971	0	0	0	565	15.00
16.00	01600	1,711	1,417	276	0	1,174	16.00
17.00	01700	1,220	0	0	0	271	17.00
18.00	01850	0	0	0	0	0	18.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	41,109	299,982	19,456	52,299	14,066	30.00
31.00	03100	1,765	25,210	1,372	2,571	1,927	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
34.00	03400	0	0	0	0	0	34.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	7,880	26,993	6,638	0	4,323	50.00
51.00	05100	0	0	0	0	705	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	53	53.00
54.00	05400	3,626	17,062	1,694	0	1,402	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	1,685	0	2,033	0	1,686	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	842	1,417	542	0	823	65.00
66.00	06600	1,240	12,604	629	0	231	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	913	28,726	0	0	134	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
90.01	09001	1,091	16,504	2,725	0	679	90.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0197

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

Worksheet B-1

Date/Time Prepared:  
2/27/2019 3:19 pm

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE)	
			7.00	8.00	9.00	10.00	11.00	
91.00	09100	EMERGENCY	2,137	0	0	0	2,677	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	09850	OTHER REIMB COST CTR	0	0	0	0	0	98.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	82,028	432,749	37,932	54,870	31,710	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	220	0	252	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	0	0	0	0	338	193.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,060,534	169,487	1,107,233	1,290,591	350,215	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	37.211045	0.391652	28.997303	23.520886	10.927827	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	125,931	3,012	163,653	80,666	24,208	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.531113	0.006960	4.285905	1.470129	0.755367	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: 14-0197

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

Worksheet B-1

Date/Time Prepared:  
2/27/2019 3:19 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NUR S. SALARY)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	SOCIAL SERVICE (TOTAL PATI ENT DAYS)	
		13.00	14.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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	9,625,950					13.00
14.00	01400	68,573	435,392				14.00
15.00	01500	360,206	0	100			15.00
16.00	01600	458,192	0	0	44,957,451		16.00
17.00	01700	55,090	0	0	0	18,290	17.00
18.00	01850	0	0	0	0	0	18.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	4,997,391	2,940	0	14,379,037	17,433	30.00
31.00	03100	0	0	0	422,973	857	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
34.00	03400	0	0	0	0	0	34.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	1,025,139	892	0	3,481,808	0	50.00
51.00	05100	178,675	0	0	762,884	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	84,452	0	0	744,806	0	53.00
54.00	05400	359,384	0	0	1,932,572	0	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	576,648	0	0	6,633,741	0	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	348,683	0	0	2,811,307	0	65.00
66.00	06600	161,847	0	0	708,781	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	65,833	0	0	986,373	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	431,291	0	2,111,129	0	71.00
72.00	07200	0	0	0	15,355	0	72.00
73.00	07300	0	0	100	5,632,811	0	73.00
74.00	07400	0	0	0	17,241	0	74.00
75.00	07500	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0197

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

Worksheet B-1

Date/Time Prepared:  
2/27/2019 3:19 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURS. SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
		13.00	14.00	15.00	16.00	17.00	
90.01	09001 PARTIAL HOSPITALIZATION	254,755	0	0	1,137,024	0	90.01
91.00	09100 EMERGENCY	631,082	269	0	3,179,609	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00	09850 OTHER REIMB COST CTR	0	0	0	0	0	98.00
99.00	09900 CMHC	0	0	0	0	0	99.00
99.10	09910 CORF	0	0	0	0	0	99.10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
105.00	10500 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600 HEART ACQUISITION	0	0	0	0	0	106.00
107.00	10700 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	10800 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300 INTEREST EXPENSE						113.00
114.00	11400 UTILIZATION REVIEW-SNF						114.00
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600 HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	9,625,950	435,392	100	44,957,451	18,290	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100 RESEARCH	0	0	0	0	0	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300 NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301 MARKETING	0	0	0	0	0	193.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,161,945	531,813	816,380	1,225,752	318,102	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.120710	1.221458	8,163.800000	0.027265	17.392127	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	17,773	80,404	24,848	26,056	12,567	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.001846	0.184670	248.480000	0.000580	0.687097	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: 14-0197

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

Worksheet B-1  
Date/Time Prepared:  
2/27/2019 3:19 pm

Cost Center Description	OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS		
	OTHER GEN SVC COST CTR (TIME SPENT)			SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	
	18.00			19.00	20.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 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 & 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
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE					17.00
18.00 01850	OTHER GEN SVC COST CTR	0				18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0			19.00
20.00 02000	NURSING SCHOOL	0		0		20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0			0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0				0 22.00
23.00 02300	PARAMED ED PROGRAM	0				23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
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
32.00 03200	CORONARY CARE UNIT	0	0	0	0	0 32.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0 33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0 34.00
40.00 04000	SUBPROVIDER - I PF	0	0	0	0	0 40.00
41.00 04100	SUBPROVIDER - I RF	0	0	0	0	0 41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0 42.00
43.00 04300	NURSERY	0	0	0	0	0 43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
45.00 04500	NURSING FACILITY	0	0	0	0	0 45.00
46.00 04600	OTHER LONG TERM CARE	0	0	0	0	0 46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	0	0	0	0 50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0 55.00
56.00 05600	RADIOISOTOPE	0	0	0	0	0 56.00
57.00 05700	CT SCAN	0	0	0	0	0 57.00
58.00 05800	MRI	0	0	0	0	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000	LABORATORY	0	0	0	0	0 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0 60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0 61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0 62.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0 63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0 75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0197

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

Worksheet B-1

Date/Time Prepared:  
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Cost Center Description	OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS		
	OTHER GEN SVC COST CTR (TIME SPENT)			SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	
	18.00			19.00	20.00	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.01 09001 PARTIAL HOSPITALIZATION	0	0	0	0	0	90.01
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
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00 09850 OTHER REIMB COST CTR	0	0	0	0	0	98.00
99.00 09900 CMHC	0	0	0	0	0	99.00
99.10 09910 CORF	0	0	0	0	0	99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00 10600 HEART ACQUISITION	0	0	0	0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 11300 INTEREST EXPENSE	0	0	0	0	0	113.00
114.00 11400 UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00 11600 HOSPICE	0	0	0	0	0	116.00
118.00 11800 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100 RESEARCH	0	0	0	0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
193.01 19301 MARKETING	0	0	0	0	0	193.01
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	0	0	0	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	0.000000	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	0	0	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.000000	0.000000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)			0		206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)			0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0197

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

Worksheet B-1  
Date/Time Prepared:  
2/27/2019 3:19 pm

Cost Center Description		PARAMED PROGRAM (ASSIGNED TIME)	
		23.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	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 & 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
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
18.00	01850	OTHER GEN SVC COST CTR	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED PROGRAM	23.00
		0	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
32.00	03200	CORONARY CARE UNIT	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	34.00
40.00	04000	SUBPROVIDER - I PF	40.00
41.00	04100	SUBPROVIDER - I RF	41.00
42.00	04200	SUBPROVIDER	42.00
43.00	04300	NURSERY	43.00
44.00	04400	SKILLED NURSING FACILITY	44.00
45.00	04500	NURSING FACILITY	45.00
46.00	04600	OTHER LONG TERM CARE	46.00
		0	
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
60.01	06001	BLOOD LABORATORY	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	63.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
75.00	07500	ASC (NON-DISTINCT PART)	75.00
		0	
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00	08800	RURAL HEALTH CLINIC	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	89.00
90.00	09000	CLINIC	90.00
90.01	09001	PARTIAL HOSPITALIZATION	90.01
		0	

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0197

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

Worksheet B-1  
Date/Time Prepared:  
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Cost Center Description		PARAMED PROGRAM (ASSIGNED TIME)	
		23.00	
91.00	09100 EMERGENCY	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS			
94.00	09400 HOME PROGRAM DIALYSIS	0	94.00
95.00	09500 AMBULANCE SERVICES	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	97.00
98.00	09850 OTHER REIMB COST CTR	0	98.00
99.00	09900 CMHC	0	99.00
99.10	09910 CORF	0	99.10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0	100.00
101.00	10100 HOME HEALTH AGENCY	0	101.00
SPECIAL PURPOSE COST CENTERS			
105.00	10500 KIDNEY ACQUISITION	0	105.00
106.00	10600 HEART ACQUISITION	0	106.00
107.00	10700 LIVER ACQUISITION	0	107.00
108.00	10800 LUNG ACQUISITION	0	108.00
109.00	10900 PANCREAS ACQUISITION	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	110.00
111.00	11100 ISLET ACQUISITION	0	111.00
113.00	11300 INTEREST EXPENSE		113.00
114.00	11400 UTILIZATION REVIEW-SNF		114.00
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)	0	115.00
116.00	11600 HOSPICE	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
191.00	19100 RESEARCH	0	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	192.00
193.00	19300 NONPAID WORKERS	0	193.00
193.01	19301 MARKETING	0	193.01
200.00	Cross Foot Adjustments		200.00
201.00	Negative Cost Centers		201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)	0	206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0197

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

Worksheet C  
Part I  
Date/Time Prepared:  
2/27/2019 3:19 pm

		Title XVIII		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	14,708,156	14,708,156	0	14,708,156	30.00	
31.00	03100 INTENSIVE CARE UNIT	1,237,688	1,237,688	0	1,237,688	31.00	
32.00	03200 CORONARY CARE UNIT	0	0	0	0	32.00	
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	33.00	
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00	
40.00	04000 SUBPROVIDER - IPF	0	0	0	0	40.00	
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	41.00	
42.00	04200 SUBPROVIDER	0	0	0	0	42.00	
43.00	04300 NURSERY	0	0	0	0	43.00	
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	44.00	
45.00	04500 NURSING FACILITY	0	0	0	0	45.00	
46.00	04600 OTHER LONG TERM CARE	0	0	0	0	46.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	2,909,797	2,909,797	0	2,909,797	50.00	
51.00	05100 RECOVERY ROOM	379,715	379,715	0	379,715	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00	
53.00	05300 ANESTHESIOLOGY	182,585	182,585	0	182,585	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,526,209	1,526,209	0	1,526,209	54.00	
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00	
56.00	05600 RADIOISOTOPE	0	0	0	0	56.00	
57.00	05700 CT SCAN	0	0	0	0	57.00	
58.00	05800 MRI	0	0	0	0	58.00	
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	59.00	
60.00	06000 LABORATORY	2,833,130	2,833,130	0	2,833,130	60.00	
60.01	06001 BLOOD LABORATORY	0	0	0	0	60.01	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00	
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	64.00	
65.00	06500 RESPIRATORY THERAPY	1,084,765	1,084,765	0	1,084,765	65.00	
66.00	06600 PHYSICAL THERAPY	558,439	558,439	0	558,439	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	68.00	
69.00	06900 ELECTROCARDIOLOGY	344,611	344,611	0	344,611	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,227,370	1,227,370	0	1,227,370	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	15,694	15,694	0	15,694	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	3,496,270	3,496,270	0	3,496,270	73.00	
74.00	07400 RENAL DIALYSIS	28,762	28,762	0	28,762	74.00	
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	75.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	88.00	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00	
90.00	09000 CLINIC	0	0	0	0	90.00	
90.01	09001 PARTIAL HOSPITALIZATION	877,292	877,292	0	877,292	90.01	
91.00	09100 EMERGENCY	1,795,590	1,795,590	0	1,795,590	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	402,109	402,109	0	402,109	92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	94.00	
95.00	09500 AMBULANCE SERVICES	0	0	0	0	95.00	
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00	
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	97.00	
98.00	09850 OTHER REIMB COST CTR	0	0	0	0	98.00	
99.00	09900 CMHC	0	0	0	0	99.00	
99.10	09910 CORF	0	0	0	0	99.10	
100.00	10000 I & R SERVICES-NOT APPRVD PRGM	0	0	0	0	100.00	
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	101.00	
<b>SPECIAL PURPOSE COST CENTERS</b>							
105.00	10500 KIDNEY ACQUISITION	0	0	0	0	105.00	
106.00	10600 HEART ACQUISITION	0	0	0	0	106.00	
107.00	10700 LIVER ACQUISITION	0	0	0	0	107.00	
108.00	10800 LUNG ACQUISITION	0	0	0	0	108.00	
109.00	10900 PANCREAS ACQUISITION	0	0	0	0	109.00	
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0	110.00	
111.00	11100 ISLET ACQUISITION	0	0	0	0	111.00	
113.00	11300 INTEREST EXPENSE	0	0	0	0	113.00	
114.00	11400 UTILIZATION REVIEW-SNF	0	0	0	0	114.00	
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	115.00	
116.00	11600 HOSPICE	0	0	0	0	116.00	

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
200.00	Subtotal (see instructions)	33,608,182	0	33,608,182	0	33,608,182	200.00
201.00	Less Observation Beds	402,109		402,109		402,109	201.00
202.00	Total (see instructions)	33,206,073	0	33,206,073	0	33,206,073	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0197		Period: From 10/01/2017 To 09/30/2018		Worksheet C Part I Date/Time Prepared: 2/27/2019 3:19 pm		
			Title XVIII			Hospital		PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio				
	Inpatient	Outpatient	Total (col. 6 + col. 7)						
	6.00	7.00	8.00				9.00	10.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>									
30.00	03000	ADULTS & PEDIATRICS	13,991,386		13,991,386				30.00
31.00	03100	INTENSIVE CARE UNIT	422,973		422,973				31.00
32.00	03200	CORONARY CARE UNIT	0		0				32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0				33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0				34.00
40.00	04000	SUBPROVIDER - I/PF	0		0				40.00
41.00	04100	SUBPROVIDER - I/RF	0		0				41.00
42.00	04200	SUBPROVIDER	0		0				42.00
43.00	04300	NURSERY	0		0				43.00
44.00	04400	SKILLED NURSING FACILITY	0		0				44.00
45.00	04500	NURSING FACILITY	0		0				45.00
46.00	04600	OTHER LONG TERM CARE	0		0				46.00
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	428,984	3,052,824	3,481,808	0.835714	0.000000		50.00
51.00	05100	RECOVERY ROOM	65,297	697,587	762,884	0.497736	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	75,748	669,058	744,806	0.245144	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,048,152	884,420	1,932,572	0.789729	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000		55.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000		56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000		57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000		59.00
60.00	06000	LABORATORY	3,836,022	2,797,719	6,633,741	0.427079	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000		60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	0.000000		61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0.000000	0.000000		62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	2,510,478	300,829	2,811,307	0.385858	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	73,112	635,669	708,781	0.787887	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	659,698	326,675	986,373	0.349372	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,179,077	932,052	2,111,129	0.581381	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,725	4,630	15,355	1.022077	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,908,768	724,043	5,632,811	0.620697	0.000000		73.00
74.00	07400	RENAL DIALYSIS	17,241	0	17,241	1.668233	0.000000		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000		75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>									
88.00	08800	RURAL HEALTH CLINIC	0	0	0				88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0				89.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000		90.00
90.01	09001	PARTIAL HOSPITALIZATION	1,260	1,135,764	1,137,024	0.771569	0.000000		90.01
91.00	09100	EMERGENCY	1,554,243	1,625,366	3,179,609	0.564720	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,178	385,473	387,651	1.037296	0.000000		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>									
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	0.000000		94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	0.000000		97.00
98.00	09850	OTHER REIMB COST CTR	0	0	0	0.000000	0.000000		98.00
99.00	09900	CMHC	0	0	0				99.00
99.10	09910	CORF	0	0	0				99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0				100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0				101.00
<b>SPECIAL PURPOSE COST CENTERS</b>									
105.00	10500	KIDNEY ACQUISITION	0	0	0				105.00
106.00	10600	HEART ACQUISITION	0	0	0				106.00
107.00	10700	LIVER ACQUISITION	0	0	0				107.00
108.00	10800	LUNG ACQUISITION	0	0	0				108.00
109.00	10900	PANCREAS ACQUISITION	0	0	0				109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0				110.00
111.00	11100	ISLET ACQUISITION	0	0	0				111.00
113.00	11300	INTEREST EXPENSE	0	0	0				113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0				114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0				115.00
116.00	11600	HOSPICE	0	0	0				116.00
200.00		Subtotal (see instructions)	30,785,342	14,172,109	44,957,451				200.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0197			Period: From 10/01/2017 To 09/30/2018		Worksheet C Part I Date/Time Prepared: 2/27/2019 3:19 pm	
		Title XVIII			Hospital		PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
		Inpatient	Outpatient	Total (col. 6 + col. 7)				
		6.00	7.00	8.00	9.00	10.00		
201.00	Less Observation Beds						201.00	
202.00	Total (see instructions)	30,785,342	14,172,109	44,957,451			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0197	Period: From 10/01/2017 To 09/30/2018	Worksheet C Part I Date/Time Prepared: 2/27/2019 3:19 pm
Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital PPS
			11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
32.00	03200	CORONARY CARE UNIT			32.00
33.00	03300	BURN INTENSIVE CARE UNIT			33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT			34.00
40.00	04000	SUBPROVIDER - I PF			40.00
41.00	04100	SUBPROVIDER - I RF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
46.00	04600	OTHER LONG TERM CARE			46.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.835714		50.00
51.00	05100	RECOVERY ROOM	0.497736		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.245144		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.789729		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.427079		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000		61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.385858		65.00
66.00	06600	PHYSICAL THERAPY	0.787887		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.349372		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.581381		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.022077		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.620697		73.00
74.00	07400	RENAL DIALYSIS	1.668233		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	PARTIAL HOSPITALIZATION	0.771569		90.01
91.00	09100	EMERGENCY	0.564720		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.037296		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
94.00	09400	HOME PROGRAM DIALYSIS	0.000000		94.00
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000		97.00
98.00	09850	OTHER REIMB COST CTR	0.000000		98.00
99.00	09900	CMHC			99.00
99.10	09910	CORF			99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM			100.00
101.00	10100	HOME HEALTH AGENCY			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
105.00	10500	KIDNEY ACQUISITION			105.00
106.00	10600	HEART ACQUISITION			106.00
107.00	10700	LIVER ACQUISITION			107.00
108.00	10800	LUNG ACQUISITION			108.00
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)			115.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

2/27/2019 3:19 pm

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0197

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

Worksheet D  
Part I  
Date/Time Prepared:  
2/27/2019 3:19 pm

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	674,752	0	674,752	17,923	37.65	30.00
31.00	INTENSIVE CARE UNIT	33,955		33,955	857	39.62	31.00
32.00	CORONARY CARE UNIT	0		0	0	0.00	32.00
33.00	BURN INTENSIVE CARE UNIT	0		0	0	0.00	33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0		0	0	0.00	34.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	0		0	0	0.00	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
45.00	NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (lines 30 through 199)	708,707		708,707	18,780		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	5,082	191,337				30.00
31.00	INTENSIVE CARE UNIT	133	5,269				31.00
32.00	CORONARY CARE UNIT	0	0				32.00
33.00	BURN INTENSIVE CARE UNIT	0	0				33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0	0				34.00
40.00	SUBPROVIDER - IPF	0	0				40.00
41.00	SUBPROVIDER - IRF	0	0				41.00
42.00	SUBPROVIDER	0	0				42.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
45.00	NURSING FACILITY	0	0				45.00
200.00	Total (lines 30 through 199)	5,215	196,606				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0197

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

Worksheet D  
Part II  
Date/Time Prepared:  
2/27/2019 3:19 pm

Cost Center Description		Capital Related Cost (from Wkst. C, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Inpatient Program Charges	PPS	
						Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	130,062	3,481,808	0.037355	134,270	5,016	50.00
51.00	05100 RECOVERY ROOM	3,179	762,884	0.004167	32,644	136	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	3,720	744,806	0.004995	39,492	197	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	77,804	1,932,572	0.040259	474,984	19,122	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MRI	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	64,486	6,633,741	0.009721	1,465,678	14,248	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0.000000	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	42,771	2,811,307	0.015214	856,018	13,023	65.00
66.00	06600 PHYSICAL THERAPY	17,244	708,781	0.024329	73,112	1,779	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	14,553	986,373	0.014754	286,871	4,232	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	90,018	2,111,129	0.042640	381,572	16,270	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	115	15,355	0.007489	5,768	43	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	64,262	5,632,811	0.011409	1,865,907	21,288	73.00
74.00	07400 RENAL DIALYSIS	192	17,241	0.011136	5,174	58	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
90.01	09001 PARTIAL HOSPITALIZATION	26,834	1,137,024	0.023600	0	0	90.01
91.00	09100 EMERGENCY	39,783	3,179,609	0.012512	437,099	5,469	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	18,447	387,651	0.047587	2,178	104	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
98.00	09850 OTHER REIMB COST CTR	0	0	0.000000	0	0	98.00
200.00	Total (lines 50 through 199)	593,470	30,543,092		6,060,767	100,985	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0197	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part III Date/Time Prepared: 2/27/2019 3:19 pm
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Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	PPS	
INPATIENT ROUTINE SERVICE COST CENTERS			1A	1.00	2A	2.00	3.00		
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	
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00	
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00	
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00	
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00	
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		
INPATIENT ROUTINE SERVICE COST CENTERS			4.00	5.00	6.00	7.00	8.00		
30.00	03000	ADULTS & PEDIATRICS	0	0	17,923	0.00	5,082	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	857	0.00	133	31.00	
32.00	03200	CORONARY CARE UNIT	0	0	0	0.00	0	32.00	
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0.00	0	33.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0.00	0	34.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	41.00	
42.00	04200	SUBPROVIDER	0	0	0	0.00	0	42.00	
43.00	04300	NURSERY	0	0	0	0.00	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0.00	0	44.00	
45.00	04500	NURSING FACILITY	0	0	0	0.00	0	45.00	
200.00		Total (lines 30 through 199)	0	0	18,780	0.00	5,215	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
INPATIENT ROUTINE SERVICE COST CENTERS			9.00						
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
32.00	03200	CORONARY CARE UNIT	0						32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0						33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0						34.00
40.00	04000	SUBPROVIDER - IPF	0						40.00
41.00	04100	SUBPROVIDER - IRF	0						41.00
42.00	04200	SUBPROVIDER	0						42.00
43.00	04300	NURSERY	0						43.00
44.00	04400	SKILLED NURSING FACILITY	0						44.00
45.00	04500	NURSING FACILITY	0						45.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0197	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/27/2019 3:19 pm
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Cost Center Description	Title XVIII						Total
	Hospital		PPS		Total		
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments		Allied Health	
1.00	2A	2.00	3A	3.00			
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	97.00
98.00	09850	OTHER REIMB COST CTR	0	0	0	0	98.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0197	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/27/2019 3:19 pm
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Cost Center Description	Title XVIII			Hospital	PPS			
	All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)			
	4.00	5.00	6.00	7.00	8.00			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	3,481,808	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	762,884	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	744,806	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	1,932,572	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	6,633,741	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0.000000	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0.000000	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,811,307	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	708,781	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	986,373	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,111,129	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	15,355	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,632,811	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	17,241	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	PARTIAL HOSPITALIZATION	0	0	0	1,137,024	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	3,179,609	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	387,651	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0.000000	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0.000000	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0.000000	97.00
98.00	09850	OTHER REIMB COST CTR	0	0	0	0	0.000000	98.00
200.00		Total (lines 50 through 199)	0	0	0	30,543,092		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0197	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/27/2019 3:19 pm
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Cost Center Description		Title XVIII					Hospital	PPS
		Outpatient Ratio of Cost to Charges (col. 6 + col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	0.000000	134,270	0	984,520	0	50.00	
51.00	05100 RECOVERY ROOM	0.000000	32,644	0	233,617	0	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00	
53.00	05300 ANESTHESIOLOGY	0.000000	39,492	0	195,608	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	474,984	0	325,039	0	54.00	
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00	
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00	
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00	
58.00	05800 MRI	0.000000	0	0	0	0	58.00	
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00	
60.00	06000 LABORATORY	0.000000	1,465,678	0	629,990	0	60.00	
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0	0	61.00	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	62.00	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00	
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00	
65.00	06500 RESPIRATORY THERAPY	0.000000	856,018	0	9,924	0	65.00	
66.00	06600 PHYSICAL THERAPY	0.000000	73,112	0	9,255	0	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00	
69.00	06900 ELECTROCARDIOLOGY	0.000000	286,871	0	110,380	0	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	381,572	0	301,630	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	5,768	0	2,490	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	1,865,907	0	380,605	0	73.00	
74.00	07400 RENAL DIALYSIS	0.000000	5,174	0	0	0	74.00	
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00	
OUTPATIENT SERVICE COST CENTERS								
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00	
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00	
90.01	09001 PARTIAL HOSPITALIZATION	0.000000	0	0	0	0	90.01	
91.00	09100 EMERGENCY	0.000000	437,099	0	388,263	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	2,178	0	45,408	0	92.00	
OTHER REIMBURSABLE COST CENTERS								
94.00	09400 HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00	
95.00	09500 AMBULANCE SERVICES	0.000000	0	0	0	0	95.00	
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00	
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00	
98.00	09850 OTHER REIMB COST CTR	0.000000	0	0	0	0	98.00	
200.00	Total (lines 50 through 199)		6,060,767	0	3,616,729	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0197	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part V Date/Time Prepared: 2/27/2019 3:19 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0.835714	984,520	0	0	822,777
51.00 05100 RECOVERY ROOM	0.497736	233,617	0	0	116,280
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0
53.00 05300 ANESTHESIOLOGY	0.245144	195,608	0	0	47,952
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.789729	325,039	0	0	256,693
55.00 05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0
56.00 05600 RADIOISOTOPE	0.000000	0	0	0	0
57.00 05700 CT SCAN	0.000000	0	0	0	0
58.00 05800 MRI	0.000000	0	0	0	0
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0
60.00 06000 LABORATORY	0.427079	629,990	0	0	269,055
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0	0
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0
64.00 06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0
65.00 06500 RESPIRATORY THERAPY	0.385858	9,924	0	0	3,829
66.00 06600 PHYSICAL THERAPY	0.787887	9,255	0	0	7,292
67.00 06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0
68.00 06800 SPEECH PATHOLOGY	0.000000	0	0	0	0
69.00 06900 ELECTROCARDIOLOGY	0.349372	110,380	0	0	38,564
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.581381	301,630	0	0	175,362
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1.022077	2,490	0	0	2,545
73.00 07300 DRUGS CHARGED TO PATIENTS	0.620697	380,605	0	2,661	236,240
74.00 07400 RENAL DIALYSIS	1.668233	0	0	0	0
75.00 07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00 08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0
90.00 09000 CLINIC	0.000000	0	0	0	0
90.01 09001 PARTIAL HOSPITALIZATION	0.771569	0	0	0	0
91.00 09100 EMERGENCY	0.564720	388,263	0	0	219,260
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.037296	45,408	0	0	47,102
<b>OTHER REIMBURSABLE COST CENTERS</b>					
94.00 09400 HOME PROGRAM DIALYSIS	0.000000	0	0	0	0
95.00 09500 AMBULANCE SERVICES	0.000000	0	0	0	0
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0
98.00 09850 OTHER REIMB COST CTR	0.000000	0	0	0	0
200.00	Subtotal (see instructions)	3,616,729	0	2,661	2,242,951
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0	0	
202.00	Net Charges (line 200 - line 201)	3,616,729	0	2,661	2,242,951

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0197	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part V Date/Time Prepared: 2/27/2019 3:19 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MRI	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1,652	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000 CLINIC	0	0	90.00
90.01	09001 PARTIAL HOSPITALIZATION	0	0	90.01
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
94.00	09400 HOME PROGRAM DIALYSIS	0	0	94.00
95.00	09500 AMBULANCE SERVICES	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	97.00
98.00	09850 OTHER REIMB COST CTR	0	0	98.00
200.00	Subtotal (see instructions)	0	1,652	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	0	1,652	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0197	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/27/2019 3:19 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		17,923	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		17,923	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)		17,433	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)		5,082	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		14,708,156	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)		14,708,156	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		14,708,156	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		820.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,170,442	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)		4,170,442	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0197	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/27/2019 3:19 pm	
Title XVIII			Hospital		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	1,237,688	857	1,444.21	133	192,080	43.00
44.00 CORONARY CARE UNIT	0	0	0.00	0	0	44.00
45.00 BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	45.00
46.00 SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	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)					3,270,965	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					7,633,487	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)					196,606	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					100,985	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					297,591	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					7,335,896	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)					490	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					820.63	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					402,109	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0197		Period: From 10/01/2017 To 09/30/2018		Worksheet D-1 Date/Time Prepared: 2/27/2019 3:19 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	674,752	14,708,156	0.045876	402,109	18,447	90.00
91.00	Nursing School cost	0	14,708,156	0.000000	402,109	0	91.00
92.00	Allied health cost	0	14,708,156	0.000000	402,109	0	92.00
93.00	All other Medical Education	0	14,708,156	0.000000	402,109	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0197	Period: From 10/01/2017 To 09/30/2018	Worksheet D-3 Date/Time Prepared: 2/27/2019 3:19 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		4,631,678	30.00
31.00	03100	INTENSIVE CARE UNIT		199,234	31.00
32.00	03200	CORONARY CARE UNIT		0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	34.00
40.00	04000	SUBPROVIDER - I PF		0	40.00
41.00	04100	SUBPROVIDER - I RF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.835714	134,270	112,211 50.00
51.00	05100	RECOVERY ROOM	0.497736	32,644	16,248 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0.245144	39,492	9,681 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.789729	474,984	375,109 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0 55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0 56.00
57.00	05700	CT SCAN	0.000000	0	0 57.00
58.00	05800	MRI	0.000000	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0 59.00
60.00	06000	LABORATORY	0.427079	1,465,678	625,960 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0 61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0 62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0 63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0.385858	856,018	330,301 65.00
66.00	06600	PHYSICAL THERAPY	0.787887	73,112	57,604 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.349372	286,871	100,225 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.581381	381,572	221,839 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.022077	5,768	5,895 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.620697	1,865,907	1,158,163 73.00
74.00	07400	RENAL DIALYSIS	1.668233	5,174	8,631 74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0 75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0 89.00
90.00	09000	CLINIC	0.000000	0	0 90.00
90.01	09001	PARTIAL HOSPITALIZATION	0.771569	0	0 90.01
91.00	09100	EMERGENCY	0.564720	437,099	246,839 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.037296	2,178	2,259 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0 94.00
95.00	09500	AMBULANCE SERVICES			0 95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0 96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0 97.00
98.00	09850	OTHER REIMB COST CTR	0.000000	0	0 98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		6,060,767	3,270,965 200.00
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)		6,060,767	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0197	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part A Date/Time Prepared: 2/27/2019 3:19 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS</b>				
1.00	DRG Amounts Other than Outlier Payments			0 1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			0 1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			6,272,923 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)			82,996 2.00
2.01	Outlier reconciliation amount			0 2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)			0 2.02
3.00	Managed Care Simulated Payments			1,857,160 3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			143.66 4.00
<b>Indirect Medical Education Adjustment</b>				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)			0.00 5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			0.00 6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			0.00 7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			0.00 7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).			0.00 8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			0.00 8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)			0.00 8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)			0.00 9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			0.00 10.00
11.00	FTE count for residents in dental and podiatric programs.			0.00 11.00
12.00	Current year allowable FTE (see instructions)			0.00 12.00
13.00	Total allowable FTE count for the prior year.			0.00 13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.			0.00 14.00
15.00	Sum of lines 12 through 14 divided by 3.			0.00 15.00
16.00	Adjustment for residents in initial years of the program			0.00 16.00
17.00	Adjustment for residents displaced by program or hospital closure			0.00 17.00
18.00	Adjusted rolling average FTE count			0.00 18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.000000 19.00
20.00	Prior year resident to bed ratio (see instructions)			0.000000 20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000 21.00
22.00	IME payment adjustment (see instructions)			0 22.00
22.01	IME payment adjustment - Managed Care (see instructions)			0 22.01
<b>Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA</b>				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).			0.00 23.00
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00 24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)			0.00 25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000 26.00
27.00	IME payments adjustment factor. (see instructions)			0.000000 27.00
28.00	IME add-on adjustment amount (see instructions)			0 28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)			0 28.01
29.00	Total IME payment (sum of lines 22 and 28)			0 29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0 29.01
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			18.00 30.00
31.00	Percentage of Medicaid patient days (see instructions)			55.99 31.00
32.00	Sum of lines 30 and 31			73.99 32.00
33.00	Allowable disproportionate share percentage (see instructions)			50.26 33.00
34.00	Disproportionate share adjustment (see instructions)			788,193 34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0197	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part A Date/Time Prepared: 2/27/2019 3:19 pm	
		Title XVIII	Hospital	PPS	
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
<b>Uncompensated Care Adjustment</b>					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)		0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	1,650,386	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	1,650,386	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,650,386		36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)</b>					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
		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)		8,794,498		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			8,794,498	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			596,355	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)			9,390,853	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			9,390,853	61.00
62.00	Deductibles billed to program beneficiaries			618,122	62.00
63.00	Coinsurance billed to program beneficiaries			181,658	63.00
64.00	Allowable bad debts (see instructions)			513,076	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			333,499	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			500,508	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			8,924,572	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			0	70.93
70.94	HRR adjustment amount (see instructions)			-20,703	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0197	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part A Date/Time Prepared: 2/27/2019 3:19 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		8,903,869	71.00
71.01	Sequestration adjustment (see instructions)		178,077	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		8,309,002	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)		416,790	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,212,569	75.00
<b>TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)</b>				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
			Prior to 10/1 1.00	On/After 10/1 2.00
100.00	HSP Bonus Payment Amount HSP bonus amount (see instructions)			0
101.00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
103.00	HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
200.00	Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment 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
201.00	Cost Reimbursement 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
204.00	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			204.00
205.00	Medicare target amount			205.00
206.00	Case-mix adjusted target amount (line 203 times line 204)			206.00
207.00	Medicare inpatient routine cost cap (line 202 times line 205)			207.00
208.00	Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the \$410A Demonstration (see instructions)			208.00
209.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			209.00
210.00	Adjustment to Medicare IPPS payments (see instructions)			210.00
211.00	Reserved for future use			211.00
212.00	Total adjustment to Medicare IPPS payments (see instructions)			212.00
213.00	Comparison of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 211)			213.00
214.00	Low-volume adjustment (see instructions)			214.00
215.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			215.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0197

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

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
2/27/2019 3:19 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	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	6,272,923	0	0	6,272,923	6,272,923	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	82,996	0	0	82,996	82,996	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	1,857,160	0	0	0	0	4.00
<b>Indirect Medical Education Adjustment</b>								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	0.000000	5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	0.000000	7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
<b>Disproportionate Share Adjustment</b>								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.5026	0.5026	0.5026	0.5026	0.5026	10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	788,193	0	0	788,193	788,193	11.00
11.01	Uncompensated care payments	36.00	1,650,386	0	0	1,650,386	1,650,386	11.01
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	8,794,498	0	0	8,794,498	8,794,498	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	8,794,498	0	0	8,794,498	8,794,498	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	596,355	0	0	596,355	596,355	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: 14-0197

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

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
2/27/2019 3:19 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	0	9,390,853	9,390,853	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	510,897	0	0	510,897	510,897	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	2,897	0	0	2,897	2,897	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	0.1616	0.1616	0.1616	0.1616		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	82,561	0	0	82,561	82,561	25.00
26.00	Total prospective capital payments (see instructions)	12.00	596,355	0	0	596,355	596,355	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	0.081607		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				766,359	766,359	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: 14-0197		Period: From 10/01/2017 To 09/30/2018		Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/27/2019 3:19 pm	
Title XVIII				Hospital		PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	6,272,923		6,272,923	6,272,923	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	82,996	0	82,996	82,996	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	1,857,160	0	0	0	4.00
<b>Indirect Medical Education Adjustment</b>							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
<b>Disproportionate Share Adjustment</b>							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.5026	0.5026	0.5026		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	788,193	0	788,193	788,193	11.00
11.01	Uncompensated care payments	36.00	1,650,386	0	1,650,386	1,650,386	11.01
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	8,794,498	0	8,794,498	8,794,498	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	8,794,498	0	8,794,498	8,794,498	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	596,355	0	596,355	596,355	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	9,390,853	9,390,853	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 14-0197	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/27/2019 3:19 pm
Title XVIII			Hospital	PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	510,897	0	510,897	510,897	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	2,897	0	2,897	2,897	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	0.1616	0.1616	0.1616		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	82,561	0	82,561	82,561	25.00
26.00	Total prospective capital payments (see instructions)	12.00	596,355	0	596,355	596,355	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	0	0	0	0	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	-20,703	0	-20,703	-20,703	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: 14-0197	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part B Date/Time Prepared: 2/27/2019 3:19 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		1,652	1.00
2.00	Medical and other services reimbursed under OPPTS (see instructions)		2,242,951	2.00
3.00	OPPTS payments		1,216,565	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)		1,652	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		2,661	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)		2,661	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		2,661	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		1,009	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)		1,652	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)		1,216,565	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		248,035	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)		970,182	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)		970,182	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		970,182	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		91,378	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		59,396	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		91,378	36.00
37.00	Subtotal (see instructions)		1,029,578	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)		1,029,578	40.00
40.01	Sequestration adjustment (see instructions)		20,592	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		1,014,642	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-5,656	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		28,313	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0197

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
2/27/2019 3:19 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		8,328,307		1,018,587	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	04/12/2018	19,305	04/12/2018	3,945	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)		-19,305		-3,945	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)		8,309,002		1,014,642	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		416,790		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		5,656	6.02	
7.00	Total Medicare program liability (see instructions)		8,725,792		1,008,986	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: 14-0197	Period: From 10/01/2017 To 09/30/2018	Worksheet E-1 Part II Date/Time Prepared: 2/27/2019 3:19 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

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

Provider CCN: 14-0197

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

Worksheet G

Date/Time Prepared:  
2/27/2019 3:19 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	3,406,180	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	100,000	0	0	0	3.00
4.00	Accounts receivable	11,834,727	0	0	0	4.00
5.00	Other receivable	4,580,337	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,490,875	0	0	0	6.00
7.00	Inventory	479,338	0	0	0	7.00
8.00	Prepaid expenses	650,889	0	0	0	8.00
9.00	Other current assets	-1,717,164	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)	15,843,432	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	1,356,313	0	0	0	12.00
13.00	Land improvements	1,334,400	0	0	0	13.00
14.00	Accumulated depreciation	-1,302,867	0	0	0	14.00
15.00	Buildings	36,203,103	0	0	0	15.00
16.00	Accumulated depreciation	-30,708,878	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	11,881,628	0	0	0	19.00
20.00	Accumulated depreciation	-11,084,370	0	0	0	20.00
21.00	Automobiles and trucks	141,008	0	0	0	21.00
22.00	Accumulated depreciation	-78,764	0	0	0	22.00
23.00	Major movable equipment	13,379,247	0	0	0	23.00
24.00	Accumulated depreciation	-12,604,291	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	8,516,529	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	517,198	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	1,518,159	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,035,357	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	26,395,318	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	5,537,459	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,515,625	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,500,000	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	0	0	0	0	43.00
44.00	Other current liabilities	707,215	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	11,260,299	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	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	3,727,105	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	3,727,105	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	14,987,404	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	11,407,914				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)	11,407,914	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	26,395,318	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0197

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

Worksheet G-1

Date/Time Prepared:  
2/27/2019 3:19 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		14,488,295			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-3,612,453				2.00
3.00	Total (sum of line 1 and line 2)		10,875,842			0	3.00
4.00	PENSION LIABILITY ADJUSTMENT	431,145		0		0	4.00
5.00	CHANGE IN TEMPORARILY RESTRICTED NET	100,927		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		532,072			0	10.00
11.00	Subtotal (line 3 plus line 10)		11,407,914			0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		11,407,914			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	PENSION LIABILITY ADJUSTMENT		0				4.00
5.00	CHANGE IN TEMPORARILY RESTRICTED NET		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	Deductions (debit adjustments) (specify)		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: 14-0197

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
2/27/2019 3:19 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
<b>General Inpatient Routine Services</b>					
1.00	Hospital	16,091,454		16,091,454	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	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	0		0	7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE	0		0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	16,091,454		16,091,454	10.00
<b>Intensive Care Type Inpatient Hospital Services</b>					
11.00	INTENSIVE CARE UNIT	422,973		422,973	11.00
12.00	CORONARY CARE UNIT	0		0	12.00
13.00	BURN INTENSIVE CARE UNIT	0		0	13.00
14.00	SURGICAL INTENSIVE CARE UNIT	0		0	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	422,973		422,973	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	16,514,427		16,514,427	17.00
18.00	Ancillary services	13,634,276	10,104,465	23,738,741	18.00
19.00	Outpatient services	1,556,592	3,147,692	4,704,284	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	0	0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC	0	0	0	24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	25.00
26.00	HOSPICE	0	0	0	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	31,705,295	13,252,157	44,957,452	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		34,905,382		29.00
30.00	BAD DEBT EXPENSES	255,102			30.00
31.00	MEDICARE PART A BAD DEBT EXPENSE	0			31.00
32.00	MEDICARE PART B BAD DEBT EXPENSES	0			32.00
33.00	NON-HOSPITAL EXPENSES	8,287,863			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		8,542,965		36.00
37.00	NON-HOSPITAL REVENUES	6,942,796			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)		6,942,796		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		36,505,551		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0197

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

Worksheet G-3

Date/Time Prepared:  
2/27/2019 3:19 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	44,957,452	1.00
2.00	Less contractual allowances and discounts on patients' accounts	12,021,444	2.00
3.00	Net patient revenues (line 1 minus line 2)	32,936,008	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	36,505,551	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,569,543	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	4,125	6.00
7.00	Income from investments	-26,957	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	-1,157	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	90,321	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	9,715	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	HIT AND E. H. R. INCENTIVE PAYMENTS	-119,680	24.00
24.01	MAINTENANCE INCOME	723	24.01
25.00	Total other income (sum of lines 6-24)	-42,910	25.00
26.00	Total (line 5 plus line 25)	-3,612,453	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-3,612,453	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0197	Period: From 10/01/2017 To 09/30/2018	Worksheet L Parts I-III Date/Time Prepared: 2/27/2019 3:19 pm
		Title XVII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		510,897	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		2,897	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)		50.11	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)		18.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		55.99	8.00
9.00	Sum of lines 7 and 8		73.99	9.00
10.00	Allowable disproportionate share percentage (see instructions)		16.16	10.00
11.00	Disproportionate share adjustment (see instructions)		82,561	11.00
12.00	Total prospective capital payments (see instructions)		596,355	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00