

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Provider CCN: 14-0304

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

Worksheet 5
Parts I-III
Date/Time Prepared:
5/28/2019 6:23 am

PART I - COST REPORT STATUS

Provider use only
1. Electronically filed cost report
2. Manually submitted cost report
3. If this is an amended report, enter the number of times the provider resubmitted this cost report
4. Medicare Utilization. Enter "F" for full or "L" for low

Contractor use only
5. Cost Report Status
(1) AS Submitted
(2) Settled without Audit
(3) Settled with Audit
(4) Reopened
(5) Amended

6. Date Received:
7. Contractor No.
8. Initial Report for this Provider CCM
9. Final Report for this Provider CCM

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

Date: 5/28/2019 Time: 6:23 am

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ADVENTIST BOLINGBROOK HOSPITAL (14-0304) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Encryption Information

ECR: Date: 5/28/2019 Time: 6:23 am
w90iwy.pj0vyt1zCqI1PFOikw7aM00
zhYZE0t:rh74YVvIw4v1VND4x2pn9M
f:40if:zwo0jJgi
PI: Date: 5/28/2019 Time: 6:23 am
ewws0LfkMEoyqFA049CtWru18Vvz70
qjJS00bflVRX9Lnv40eezXW5.mgjhZ
mx080NCJUM0v2781

(signed)

Officer or Administrator of Provider(s)

Title

Date

JPLCOO
5-28-19

	Title XVIII					Title XIX	Total
	Title V 1.00	Part A 2.00	Part B 3.00	HIT 4.00	5.00		
PART III - SETTLEMENT SUMMARY							
1.00 Hospital	0	-3,995	68,072	0	0	0	1.00
2.00 Subprovider - IPF	0	3	-430	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	0	6.00
200.00 Total	0	-3,992	67,642	0	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.

PLEASE BE AWARE THAT THIS IS A SCANNED SIGNATURE. DUE TO INCLEMENT WEATHER THE ORIGINAL SIGNATURES HAVE BEEN DELAYED AT THE FEDERAL EXPRESS CENTER IN MEMPHIS TENN SINCE WEDNESDAY 5/29/2019. ORIGINAL SIGNATURES WILL FOLLOW ONCE FEDERAL EXPRESS DELIVERS.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0304			Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part I Date/Time Prepared: 5/28/2019 6:23 am				
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days				
		1.00	2.00	3.00	4.00	5.00	6.00				
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0			25.00		
						Urban/Rural	Date of Geogr				
						1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.							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	XVIII	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	Y	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.										57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete wkst. D-5.							N			58.00
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete wkst. D-2, Pt. I.							N			59.00
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code					
				1.00	2.00	3.00					
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)							N			60.00

	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00	N			0.00	0.00	61.00
61.01						61.01
61.02						61.02
61.03						61.03
61.04						61.04
61.05						61.05
61.06						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				0.00	0.00	61.10
61.20				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00					0.00	62.00
62.01					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00	N					63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA 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			0.00	0.00	0.000000	64.00

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

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

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		1.00	2.00			
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00
		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	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:	2,094,309	0	0		
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the worksheet A line number where these taxes are included.	N				122.00
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		HF8013		140.00

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		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: ADVENTHEALTH	Contractor's Name: FIRST COAST SERVICE OPTIONS		Contractor's Number: 09001			141.00	
142.00	Street: 900 HOPE WAY	PO Box:					142.00	
143.00	City: ALTAMONTE SPRINGS	State: FL		Zip Code: 32714			143.00	
144.00 Are provider based physicians' costs included in worksheet A?							1.00	
							Y	
145.00 If costs for renal services are claimed on wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							1.00	
							Y	
146.00 Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.							2.00	
							N	
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							1.00	
							N	
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							1.00	
							N	
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							1.00	
							N	
		Part A	Part B	Title V	Title XIX			
		1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital	N	N	N	N			155.00
156.00	Subprovider - IPF	N	N	N	N			156.00
157.00	Subprovider - IRF	N	N	N	N			157.00
158.00	SUBPROVIDER							158.00
159.00	SNF	N	N	N	N			159.00
160.00	HOME HEALTH AGENCY	N	N	N	N			160.00
161.00	CMHC	N	N	N	N			161.00
165.00 Multicampus Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							1.00	
							N	
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	
							1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						9.99	169.00
				Beginning	Ending			
				1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			10/01/2017	09/30/2018			
							1.00	
							2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N	0

		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	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
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.	N		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
		Y/N	Legal Oper.	
		1.00	2.00	
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on worksheet A? If yes, see instructions.	N		11.00
		Y/N		
		1.00		
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		Y	15.00
		Part A		Part B
		Y/N	Date	Y/N
		1.00	2.00	3.00
				Date
				4.00
PS&R Data				
16.00	was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		16.00
17.00	was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/01/2019	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		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		19.00

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N	N	21.00
					1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
					1.00
					2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MIKE		THOMPSON	41.00
42.00	Enter the employer/company name of the cost report preparer.	ADVENTHEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	407-357-2338		MIKE.M.THOMPSON@ADVENTHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0304	Period: From 01/01/2018 To 12/31/2018	worksheet S-2 Part II Date/Time Prepared: 5/28/2019 6:23 am
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT MANAGER		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: 14-0304

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

worksheet S-3
Part I
Date/Time Prepared:
5/28/2019 6:23 am

Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	I/P Days / O/P	Title V
	Line Number		Available		Visits / Trips	
	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	98	35,770	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)		98	35,770	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,380	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		110	40,150	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	24	8,760		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		134			0	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

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	6,026	377	17,476			1.00
2.00 HMO and other (see instructions)	2,541	5,166				2.00
3.00 HMO IPF Subprovider	614	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	6,026	377	17,476			7.00
8.00 INTENSIVE CARE UNIT	930	34	2,399			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		466	2,872			13.00
14.00 Total (see instructions)	6,956	877	22,747	0.00	824.90	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	5,165	47	6,249	0.00	66.31	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)			144			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	891.21	27.00
28.00 Observation Bed Days		117	3,398			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	37	165			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

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title v	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	1,680	263	5,834	1.00
2.00 HMO and other (see instructions)				614	1,008		2.00
3.00 HMO IPF Subprovider					2		3.00
4.00 HMO IRF Subprovider					0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0	1,680	263	5,834		14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF	0.00	0	340	2	452		16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00						26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days				0			33.00
33.01 LTCH site neutral days and discharges				0			33.01

	wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	38,711,060	70,203	38,781,263	1,853,722.00	20.92 1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00 2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00 3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00 4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00 4.01
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00 5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00 6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00 7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00 7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00 8.00
9.00	SNF	44.00	0	0	0	0.00	0.00 9.00
10.00	Excluded area salaries (see instructions)		2,840,592	0	2,840,592	156,601.00	18.14 10.00
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		332,325	0	332,325	7,589.00	43.79 11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00 12.00
13.00	Contract labor: Physician-Part A - Administrative		129,050	0	129,050	1,572.00	82.09 13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00 14.00
14.01	Home office salaries		0	0	0	0.00	0.00 14.01
14.02	Related organization salaries		0	0	0	0.00	0.00 14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00 15.00
16.00	Home office and Contract Physicians Part A - Teaching		4,487,368	0	4,487,368	74,076.00	60.58 16.00
WAGE-RELATED COSTS							
17.00	wage-related costs (core) (see instructions)		7,776,783	0	7,776,783		
18.00	wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		604,812	0	604,812		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		1,210,669	0	1,210,669		
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		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	-80,779	80,779	0	0.00	0.00 26.00
27.00	Administrative & General	5.00	2,960,849	500	2,961,349	84,531.00	35.03 27.00

	1.00	2.00	3.00	4.00	5.00	6.00	
	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)	
28.00	Administrative & General under contract (see inst.)	39,964	0	39,964	228.00	175.28	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	1,276,946	0	1,276,946	84,063.00	15.19	30.00
31.00	Laundry & Linen Service	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)	1,892,502	0	1,892,502	92,587.00	20.44	33.00
34.00	Dietary	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)	1,578,262	0	1,578,262	65,464.00	24.11	35.00
36.00	Cafeteria	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	1,043,143	0	1,043,143	28,632.00	36.43	38.00
39.00	Central Services and Supply	156,083	0	156,083	16,232.00	9.62	39.00
40.00	Pharmacy	1,668,341	0	1,668,341	52,834.00	31.58	40.00
41.00	Medical Records & Medical Records Library	269,538	0	269,538	13,863.00	19.44	41.00
42.00	Social Service	616,034	0	616,034	16,755.00	36.77	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	42,221,788	70,203	42,291,991	2,012,001.00	21.02	1.00
2.00	Excluded area salaries (see instructions)	2,840,592	0	2,840,592	156,601.00	18.14	2.00
3.00	Subtotal salaries (line 1 minus line 2)	39,381,196	70,203	39,451,399	1,855,400.00	21.26	3.00
4.00	Subtotal other wages & related costs (see inst.)	461,375	0	461,375	9,161.00	50.36	4.00
5.00	Subtotal wage-related costs (see inst.)	8,987,452	0	8,987,452	0.00	22.78	5.00
6.00	Total (sum of lines 3 thru 5)	48,830,023	70,203	48,900,226	1,864,561.00	26.23	6.00
7.00	Total overhead cost (see instructions)	11,420,883	81,279	11,502,162	455,189.00	25.27	7.00

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	1,344,719	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	3,691,459	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	14,586	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	298,407	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	2,871,018	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	61,842	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	99,564	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	8,381,595	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0304

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

Worksheet S-3
Part V
Date/Time Prepared:
5/28/2019 6:23 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	332,325	8,381,595	1.00
2.00	Hospital	332,325	8,381,595	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0304	Period: From 01/01/2018 To 12/31/2018	Worksheet S-10 Date/Time Prepared: 5/28/2019 6:23 am
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				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.215343	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			12,295,719	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			104,181,175	6.00
7.00	Medicaid cost (line 1 times line 6)			22,434,687	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)			10,138,968	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP			0	9.00
10.00	Stand-alone CHIP charges			0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			24,664	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			10,138,968	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
Uncompensated care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	9,288,716	655,372	9,944,088	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,000,260	655,372	2,655,632	21.00
22.00	Payments received from patients for amounts previously written off as charity care	68,226	58,430	126,656	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,932,034	596,942	2,528,976	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)			6,804,180	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			387,659	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			596,398	27.01
28.00	Non-Medicare bad debt expense (see instructions)			6,207,782	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			1,545,541	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			4,074,517	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			14,213,485	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0304

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

worksheet A
Date/Time Prepared:
5/28/2019 6:23 am

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	0	0	7,171,616	7,171,616	1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	0	0	2,915,786	2,915,786	2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	-80,779	5,550,087	5,469,308	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	2,960,849	31,454,509	34,415,358	-170,768	5.00
7.00 00700	OPERATION OF PLANT	1,276,946	3,752,523	5,029,469	-16,391	7.00
9.00 00900	HOUSEKEEPING	0	2,389,478	2,389,478	-1,592	9.00
10.00 01000	DIETARY	0	2,472,642	2,472,642	-1,863,754	10.00
11.00 01100	CAFETERIA	0	0	0	1,863,754	11.00
13.00 01300	NURSING ADMINISTRATION	1,043,143	497,294	1,540,437	-14,945	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	156,083	396,987	553,070	-588,062	14.00
15.00 01500	PHARMACY	1,668,341	7,043,782	8,712,123	-6,793,373	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	269,538	42,618	312,156	-110	16.00
17.00 01700	SOCIAL SERVICE	616,034	185,619	801,653	-20	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	8,097,775	1,202,680	9,300,455	-1,215,934	30.00
31.00 03100	INTENSIVE CARE UNIT	2,094,911	1,146,524	3,241,435	-370,316	31.00
40.00 04000	SUBPROVIDER - IPF	2,211,369	289,481	2,500,850	-56,491	40.00
43.00 04300	NURSERY	0	37,273	37,273	1,327,809	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	3,752,482	10,886,226	14,638,708	-7,647,273	50.00
51.00 05100	RECOVERY ROOM	588,262	61,115	649,377	-13,650	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,672,586	794,204	2,466,790	-532,633	52.00
53.00 05300	ANESTHESIOLOGY	50,618	287,277	337,895	-228,356	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,339,589	1,611,374	3,950,963	-1,207,077	54.00
56.00 05600	RADIOISOTOPE	168,803	-23,585	145,218	59,722	56.00
57.00 05700	CT SCAN	475,610	259,616	735,226	129,534	57.00
58.00 05800	MRI	230,326	33,126	263,452	64,386	58.00
59.00 05900	CARDIAC CATHETERIZATION	535,216	900,679	1,435,895	-798,539	59.00
60.00 06000	LABORATORY	1,522,466	2,118,688	3,641,154	-1,039,098	60.00
65.00 06500	RESPIRATORY THERAPY	820,074	261,957	1,082,031	-99,938	65.00
66.00 06600	PHYSICAL THERAPY	0	4,862,616	4,862,616	-354,855	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	62,724	62,724	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	10,975	10,975	0	68.00
69.00 06900	ELECTROCARDIOLOGY	532,055	444,687	976,742	-28,240	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	30,402	283,298	313,700	-404	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	6,017,530	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,470,860	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,594,326	73.00
74.00 07400	RENAL DIALYSIS	0	386,801	386,801	0	74.00
76.00 03020	ANCILLARY	0	0	0	0	76.00
76.01 03950	WOUND CARE	5,118	16,915	22,033	-4,463	76.01
76.97 07697	CARDIAC REHABILITATION	132,191	12,701	144,892	-1,228	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	1,070,567	356,628	1,427,195	-182,129	90.00
91.00 09100	EMERGENCY	3,841,262	1,503,875	5,345,137	-600,651	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE		8,505,329	8,505,329	-7,785,033	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	38,081,837	90,098,723	128,180,560	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	100,761	18,502	119,263	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	2,500,983	2,500,983	0	192.00
194.00 07950	FOUNDATION	112,290	27,788	140,078	0	194.00
194.01 07951	MARKETING	0	0	0	0	194.01
194.02 07952	PROF OFFICE BUILDINGS	0	78,737	78,737	0	194.02
194.03 07953	OP PHARMACY	284,833	1,677,814	1,962,647	0	194.03
194.04 07954	OTHER NONREIMBURSABLE COST CENTERS	131,339	112,427	243,766	0	194.04
200.00	TOTAL (SUM OF LINES 118 through 199)	38,711,060	94,514,974	133,226,034	0	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0304

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

worksheet A

Date/Time Prepared:
5/28/2019 6:23 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	132,324	7,303,940	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	465,482	3,381,268	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-665,920	4,803,388	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-6,546,885	27,697,705	5.00
7.00	00700	OPERATION OF PLANT	-31,442	4,981,636	7.00
9.00	00900	HOUSEKEEPING	0	2,387,886	9.00
10.00	01000	DIETARY	-475,394	133,494	10.00
11.00	01100	CAFETERIA	0	1,863,754	11.00
13.00	01300	NURSING ADMINISTRATION	-7,000	1,518,492	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-4,219	-39,211	14.00
15.00	01500	PHARMACY	-943	1,917,807	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	702,851	1,014,897	16.00
17.00	01700	SOCIAL SERVICE	-125,532	676,101	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-119,748	7,964,773	30.00
31.00	03100	INTENSIVE CARE UNIT	-38,793	2,832,326	31.00
40.00	04000	SUBPROVIDER - IPF	-12,625	2,431,734	40.00
43.00	04300	NURSERY	-1,153	1,363,929	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-611,593	6,379,842	50.00
51.00	05100	RECOVERY ROOM	0	635,727	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-418,501	1,515,656	52.00
53.00	05300	ANESTHESIOLOGY	-916	108,623	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-193,816	2,550,070	54.00
56.00	05600	RADIOISOTOPE	0	204,940	56.00
57.00	05700	CT SCAN	-316	864,444	57.00
58.00	05800	MRI	0	327,838	58.00
59.00	05900	CARDIAC CATHETERIZATION	-14,095	623,261	59.00
60.00	06000	LABORATORY	-1,552	2,600,504	60.00
65.00	06500	RESPIRATORY THERAPY	-11,713	970,380	65.00
66.00	06600	PHYSICAL THERAPY	-771	4,506,990	66.00
67.00	06700	OCCUPATIONAL THERAPY	-52	62,672	67.00
68.00	06800	SPEECH PATHOLOGY	-31	10,944	68.00
69.00	06900	ELECTROCARDIOLOGY	-284,599	663,903	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-64,422	248,874	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-678	6,016,852	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	-3,614	5,467,246	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-16,484	6,577,842	73.00
74.00	07400	RENAL DIALYSIS	0	386,801	74.00
76.00	03020	ANCILLARY	0	0	76.00
76.01	03950	WOUND CARE	-12,944	4,626	76.01
76.97	07697	CARDIAC REHABILITATION	-5,469	138,195	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-43,751	1,201,315	90.00
91.00	09100	EMERGENCY	-486,737	4,257,749	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-720,296	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-9,621,347	118,559,213	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	119,263	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,500,983	192.00
194.00	07950	FOUNDATION	0	140,078	194.00
194.01	07951	MARKETING	0	0	194.01
194.02	07952	PROF OFFICE BUILDINGS	0	78,737	194.02
194.03	07953	OP PHARMACY	0	1,962,647	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	243,766	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-9,621,347	123,604,687	200.00

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - CAFETERIA					
1.00	CAFETERIA	11.00	0	1,863,754	1.00
	0		0	1,863,754	
B - NURSERY					
1.00	NURSERY	43.00	1,078,591	279,245	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	34,427	2.00
	0		1,078,591	313,672	
C - PROPERTY					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	63,909	1.00
	0		0	63,909	
D - RADIOLOGY ADMIN					
1.00	RADIOISOTOPE	56.00	14,323	6,292	1.00
2.00	CT SCAN	57.00	145,498	63,918	2.00
3.00	MRI	58.00	51,621	22,677	3.00
	0		211,442	92,887	
E - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,641,986	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	590,032	2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	132	3.00
	0		0	2,232,150	
F - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,375,617	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,321,277	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
	0		0	5,696,894	
H - BILLABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	6,017,530	1.00
2.00	RADIOISOTOPE	56.00	0	43,214	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
	0		0	6,060,744	
I - DRUGS CHARGED TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	6,594,326	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
0			0	6,594,326	
J - RENT AND LEASES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	953,935	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	995,477	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	19,761	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
0			0	1,969,173	
K - INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	136,169	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	9,000	2.00
0			0	145,169	
L - IMPLANTIBLES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	5,470,860	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
0			0	5,470,860	
M - LAUNDRY SERVICES					
1.00	HOUSEKEEPING	9.00	0	2,083	1.00
0			0	2,083	
N - RECRUITMENT BONUS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	9,000	0	1.00
0			9,000	0	
O - PHYS RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	500	0	1.00
2.00	OPERATING ROOM	50.00	0	563	2.00
3.00	CLINIC	90.00	0	10,513	3.00
	TOTALS		500	11,076	
P - CLEAR NEGATIVE SALARIES					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	71,779	0	1.00
	TOTALS		71,779	0	
500.00	Grand Total: Increases		1,371,312	30,516,697	500.00

		Decreases				
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - CAFETERIA						
1.00	DIETARY	10.00	0	1,863,754	0	1.00
	0		0	1,863,754		
B - NURSERY						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	35,096	313,672	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	1,043,495	0	0	2.00
	0		1,078,591	313,672		
C - PROPERTY						
1.00	INTEREST EXPENSE	113.00	0	63,909	13	1.00
	0		0	63,909		
D - RADIOLOGY ADMIN						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	211,442	92,887	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	0		211,442	92,887		
E - INTEREST RECLASS						
1.00	INTEREST EXPENSE	113.00	0	2,232,150	11	1.00
2.00		0.00	0	0	11	2.00
3.00		0.00	0	0	0	3.00
	0		0	2,232,150		
F - DEPRECIATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	22,748	9	1.00
2.00	OPERATION OF PLANT	7.00	0	14,669	9	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	4,316	0	3.00
4.00	SUBPROVIDER - IPF	40.00	0	11,135	0	4.00
5.00	NURSERY	43.00	0	613	0	5.00
6.00	OPERATING ROOM	50.00	0	58,068	0	6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	53,247	0	7.00
8.00	RADIOISOTOPE	56.00	0	4,107	0	8.00
9.00	MRI	58.00	0	4,140	0	9.00
10.00	LABORATORY	60.00	0	2,923	0	10.00
11.00	RESPIRATORY THERAPY	65.00	0	9,657	0	11.00
12.00	ELECTROCARDIOLOGY	69.00	0	19,825	0	12.00
13.00	EMERGENCY	91.00	0	2,472	0	13.00
14.00	INTEREST EXPENSE	113.00	0	5,488,974	0	14.00
	0		0	5,696,894		
H - BILLABLE SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	562,032	0	1.00
2.00	PHARMACY	15.00	0	45,519	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	225,808	0	3.00
4.00	INTENSIVE CARE UNIT	31.00	0	324,760	0	4.00
5.00	SUBPROVIDER - IPF	40.00	0	45,333	0	5.00
6.00	NURSERY	43.00	0	29,411	0	6.00
7.00	OPERATING ROOM	50.00	0	2,261,674	0	7.00
8.00	RECOVERY ROOM	51.00	0	13,625	0	8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	0	182,179	0	9.00
10.00	ANESTHESIOLOGY	53.00	0	89,727	0	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	64,129	0	11.00
12.00	CT SCAN	57.00	0	79,880	0	12.00
13.00	MRI	58.00	0	5,172	0	13.00
14.00	CARDIAC CATHETERIZATION	59.00	0	508,003	0	14.00
15.00	LABORATORY	60.00	0	919,009	0	15.00
16.00	RESPIRATORY THERAPY	65.00	0	61,374	0	16.00
17.00	ELECTROCARDIOLOGY	69.00	0	7,834	0	17.00
18.00	ELECTROENCEPHALOGRAPHY	70.00	0	404	0	18.00
19.00	WOUND CARE	76.01	0	4,463	0	19.00
20.00	CARDIAC REHABILITATION	76.97	0	1,228	0	20.00
21.00	CLINIC	90.00	0	35,405	0	21.00
22.00	EMERGENCY	91.00	0	593,775	0	22.00
	0		0	6,060,744		
I - DRUGS CHARGED TO PATIENTS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,177	0	1.00
2.00	PHARMACY	15.00	0	6,428,953	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	786	0	3.00
4.00	INTENSIVE CARE UNIT	31.00	0	234	0	4.00
5.00	SUBPROVIDER - IPF	40.00	0	23	0	5.00
6.00	NURSERY	43.00	0	3	0	6.00
7.00	OPERATING ROOM	50.00	0	20,847	0	7.00
8.00	RECOVERY ROOM	51.00	0	25	0	8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	0	1,386	0	9.00
10.00	ANESTHESIOLOGY	53.00	0	138,569	0	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	192	0	11.00
12.00	CT SCAN	57.00	0	2	0	12.00
13.00	MRI	58.00	0	600	0	13.00

Decreases							
Cost Center	Line #	Salary	Other	wkst. A-7	Ref.		
6.00	7.00	8.00	9.00	10.00			
14.00	CARDIAC CATHETERIZATION	59.00	0	35	0	14.00	
15.00	LABORATORY	60.00	0	11	0	15.00	
16.00	ELECTROCARDIOLOGY	69.00	0	3	0	16.00	
17.00	CLINIC	90.00	0	1	0	17.00	
18.00	EMERGENCY	91.00	0	1,479	0	18.00	
0			0	6,594,326			
J - RENT AND LEASES							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,983	10	1.00	
2.00	OPERATION OF PLANT	7.00	0	1,722	10	2.00	
3.00	HOUSEKEEPING	9.00	0	3,675	0	3.00	
4.00	NURSING ADMINISTRATION	13.00	0	14,945	0	4.00	
5.00	PHARMACY	15.00	0	318,901	0	5.00	
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	110	0	6.00	
7.00	SOCIAL SERVICE	17.00	0	20	0	7.00	
8.00	INTENSIVE CARE UNIT	31.00	0	45,192	0	8.00	
9.00	OPERATING ROOM	50.00	0	177,600	0	9.00	
10.00	DELIVERY ROOM & LABOR ROOM	52.00	0	20	0	10.00	
11.00	ANESTHESIOLOGY	53.00	0	60	0	11.00	
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	783,097	0	12.00	
13.00	CARDIAC CATHETERIZATION	59.00	0	1,665	0	13.00	
14.00	LABORATORY	60.00	0	117,155	0	14.00	
15.00	RESPIRATORY THERAPY	65.00	0	28,250	0	15.00	
16.00	PHYSICAL THERAPY	66.00	0	354,855	0	16.00	
17.00	ELECTROCARDIOLOGY	69.00	0	220	0	17.00	
18.00	CLINIC	90.00	0	118,633	0	18.00	
19.00	EMERGENCY	91.00	0	70	0	19.00	
0			0	1,969,173			
K - INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	145,169	12	1.00	
2.00		0.00	0	0	12	2.00	
0			0	145,169			
L - IMPLANTIBLES							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	20,537	0	1.00	
2.00	ADULTS & PEDIATRICS	30.00	0	33	0	2.00	
3.00	INTENSIVE CARE UNIT	31.00	0	130	0	3.00	
4.00	OPERATING ROOM	50.00	0	5,129,084	0	4.00	
5.00	DELIVERY ROOM & LABOR ROOM	52.00	0	280	0	5.00	
6.00	CARDIAC CATHETERIZATION	59.00	0	288,836	0	6.00	
7.00	RESPIRATORY THERAPY	65.00	0	657	0	7.00	
8.00	ELECTROCARDIOLOGY	69.00	0	358	0	8.00	
9.00	CLINIC	90.00	0	28,090	0	9.00	
10.00	EMERGENCY	91.00	0	2,855	0	10.00	
0			0	5,470,860			
M - LAUNDRY SERVICES							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,083	0	1.00	
0			0	2,083			
N - RECRUITMENT BONUS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	9,000	0	1.00	
0			0	9,000			
O - PHYS RECLASS							
1.00	OPERATING ROOM	50.00	563	0	0	1.00	
2.00	CLINIC	90.00	10,513	0	0	2.00	
3.00	ADMINISTRATIVE & GENERAL	5.00	0	500	0	3.00	
	TOTALS		11,076	500			
P - CLEAR NEGATIVE SALARIES							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	71,779	0	1.00	
	TOTALS		0	71,779			
500.00	Grand Total: Decreases		1,301,109	30,586,900		500.00	

	Beginning Balances	Acquisitions			Disposals and Retirements		
		Purchases	Donation	Total			
	1.00	2.00	3.00	4.00	5.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	5,440,226	0	0	0	1,690,226	1.00
2.00	Land Improvements	84,552	227,483	0	227,483	0	2.00
3.00	Buildings and Fixtures	111,966,702	56,119	0	56,119	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	23,136,181	0	0	0	0	5.00
6.00	Movable Equipment	40,440,398	0	0	0	924,202	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	181,068,059	283,602	0	283,602	2,614,428	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	181,068,059	283,602	0	283,602	2,614,428	10.00
	Ending Balance		Fully Depreciated Assets				
	6.00		7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	3,750,000	0				1.00
2.00	Land Improvements	312,035	0				2.00
3.00	Buildings and Fixtures	112,022,821	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	23,136,181	0				5.00
6.00	Movable Equipment	39,516,196	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	178,737,233	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	178,737,233	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0304

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

Worksheet A-7
Part II
Date/Time Prepared:
5/28/2019 6:23 am

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0304

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

Worksheet A-7
Part III
Date/Time Prepared:
5/28/2019 6:23 am

Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	139,221,037	0	139,221,037	0.778915	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	39,516,196	0	39,516,196	0.221085	0	2.00
3.00	Total (sum of lines 1-2)	178,737,233	0	178,737,233	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	4,375,617	953,935	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,321,277	995,477	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,696,894	1,949,412	3.00
Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	1,838,219	136,169	0	0	7,303,940	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,055,514	9,000	0	0	3,381,268	2.00
3.00	Total (sum of lines 1-2)	2,893,733	145,169	0	0	10,685,208	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)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-49,224	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)	A	-25,113	OPERATION OF PLANT	7.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-1,162,866			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	3,313,317			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	0	DIETARY	10.00	0	14.00
15.00 Rental of quarters to employee and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients		0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	0	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
19.01 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
20.00 Vending machines		0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant		0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on worksheet A To/From which the Amount is to be Adjusted			wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0 32.00
33.00 COLLECTION FEES	A	-5,000	ADMINISTRATIVE & GENERAL		5.00	0 33.00
33.01 OTHER REVENUE	B	-540,671	ADMINISTRATIVE & GENERAL		5.00	0 33.01
33.02 OTHER REVENUE	B	-6,063	OPERATION OF PLANT		7.00	9 33.02
33.03 OTHER REVENUE	B	-475,394	DIETARY		10.00	0 33.03
33.04 OTHER REVENUE	B	-7,000	NURSING ADMINISTRATION		13.00	0 33.04
33.05 OTHER REVENUE	B	-978	MEDICAL RECORDS & LIBRARY		16.00	0 33.05
33.06 OTHER REVENUE	B	-450	ADULTS & PEDIATRICS		30.00	0 33.06
33.07 OTHER REVENUE	B	-22,586	DELIVERY ROOM & LABOR ROOM		52.00	0 33.07
33.08 OTHER REVENUE	B	-9,333	RADIOLOGY-DIAGNOSTIC		54.00	0 33.08
33.09 OTHER REVENUE	B	-14,079	CARDIAC CATHETERIZATION		59.00	0 33.09
33.10 OTHER REVENUE	B	-5,469	CARDIAC REHABILITATION		76.97	0 33.10
33.11 STATE ASSESSMENT	A	-5,750,939	ADMINISTRATIVE & GENERAL		5.00	0 33.11
33.12 CHARITY & COMMUNITY SERVICES	A	-2,250	ADMINISTRATIVE & GENERAL		5.00	0 33.12
33.13 CHARITY & COMMUNITY SERVICES	A	-45,623	SOCIAL SERVICE		17.00	0 33.13
33.14 ENTERTAINMENT	A	-652	ADMINISTRATIVE & GENERAL		5.00	0 33.14
33.15 ENTERTAINMENT	A	-16	CARDIAC CATHETERIZATION		59.00	0 33.15
33.16 MALPRACTICE	A	-2,094,309	ADMINISTRATIVE & GENERAL		5.00	0 33.16
33.17 DUES & LOBBYING	A	-43,658	ADMINISTRATIVE & GENERAL		5.00	0 33.17
33.18 DUES & LOBBYING	A	-943	PHARMACY		15.00	0 33.18
33.19 DUES & LOBBYING	A	-65	ADMINISTRATIVE & GENERAL		5.00	0 33.19
33.20 DUES & LOBBYING	A	-69	ADMINISTRATIVE & GENERAL		5.00	0 33.20
33.21 ADVERTISING & MARKETING	A	-2,803	ADMINISTRATIVE & GENERAL		5.00	0 33.21
33.22 ADVERTISING & MARKETING	A	-1,153	NURSERY		43.00	0 33.22
33.23 PROPERTY TAXES	A	-63,909	CAP REL COSTS-BLDG & FIXT		1.00	13 33.23
33.24 NON ALLOW PHYSICIAN FEES	A	-51,684	ADMINISTRATIVE & GENERAL		5.00	0 33.24
33.25 NON ALLOW PHYSICIAN FEES	A	-607,668	OPERATING ROOM		50.00	0 33.25
33.26 NON ALLOW PHYSICIAN FEES	A	-395,915	DELIVERY ROOM & LABOR ROOM		52.00	0 33.26
33.27 NON ALLOW PHYSICIAN FEES	A	-131,294	RADIOLOGY-DIAGNOSTIC		54.00	0 33.27
33.28 NON ALLOW PHYSICIAN FEES	A	-29,167	ELECTROCARDIOLOGY		69.00	0 33.28
33.29 NON ALLOW PHYSICIAN FEES	A	-57,062	ELECTROENCEPHALOGRAPHY		70.00	0 33.29
33.30 NON ALLOW PHYSICIAN FEES	A	-37,141	CLINIC		90.00	0 33.30
33.31 NON ALLOW PHYSICIAN FEES	A	-448,484	EMERGENCY		91.00	0 33.31
33.32 HOSPICE	A	-3,331	OPERATING ROOM		50.00	0 33.32
33.33 HOSPICE	A	-102	ANESTHESIOLOGY		53.00	0 33.33
33.34 HOSPICE	A	-1,152	RADIOLOGY-DIAGNOSTIC		54.00	0 33.34
33.35 HOSPICE	A	-316	CT SCAN		57.00	0 33.35
33.36 HOSPICE	A	-1,552	LABORATORY		60.00	0 33.36
33.37 HOSPICE	A	-3,652	RESPIRATORY THERAPY		65.00	0 33.37
33.38 HOSPICE	A	-771	PHYSICAL THERAPY		66.00	0 33.38
33.39 HOSPICE	A	-52	OCCUPATIONAL THERAPY		67.00	0 33.39
33.40 HOSPICE	A	-31	SPEECH PATHOLOGY		68.00	0 33.40
33.41 HOSPICE	A	-283	ELECTROCARDIOLOGY		69.00	0 33.41
33.42 HOSPICE	A	-678	MEDICAL SUPPLIES CHARGED TO PATIENT		71.00	0 33.42
33.43 HOSPICE	A	-3,614	IMPL. DEV. CHARGED TO PATIENTS		72.00	0 33.43
33.44 HOSPICE	A	-16,484	DRUGS CHARGED TO PATIENTS		73.00	0 33.44
33.45 HOSPICE	A	-1,921	EMERGENCY		91.00	0 33.45
33.46 HOSPICE	A	-119,298	ADULTS & PEDIATRICS		30.00	0 33.46
33.47 HOSPICE	A	-10,845	INTENSIVE CARE UNIT		31.00	0 33.47
33.48 LEGAL	A	-4,219	CENTRAL SERVICES & SUPPLY		14.00	0 33.48
33.49 FEDERAL & STATE INCOME TAX	A	-5,938	ELECTROCARDIOLOGY		69.00	0 33.49
33.50 FEDERAL & STATE INCOME TAX	A	-10	CLINIC		90.00	0 33.50
33.51 AMBULANCE	A	-266	OPERATION OF PLANT		7.00	0 33.51
33.52 AMBULANCE	A	-407	INTENSIVE CARE UNIT		31.00	0 33.52
33.53 AMBULANCE	A	-814	ANESTHESIOLOGY		53.00	0 33.53
33.54 AMBULANCE	A	-562	EMERGENCY		91.00	0 33.54
33.55 SELF INSURANCE	A	-663,104	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.55
33.56 NON ALLOWABLE BORROWING	A	-6,232	INTEREST EXPENSE		113.00	0 33.56
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-9,621,347				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.

Provider CCN: 14-0304

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

Worksheet A-8
Date/Time Prepared:
5/28/2019 6:23 am

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

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: 14-0304

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

Worksheet A-8-1

Date/Time Prepared: 5/28/2019 6:23 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED					
HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	AHS HOME OFFICE	139,965	0
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	AHS HOME OFFICE	465,482	0
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	AHS HOME OFFICE	17,506	20,322
3.01	5.00	ADMINISTRATIVE & GENERAL	AHS HOME OFFICE	7,603,110	6,433,538
3.02	16.00	MEDICAL RECORDS & LIBRARY	AHS HOME OFFICE	703,829	0
3.03	113.00	INTEREST EXPENSE	AHS HOME OFFICE	2,238,382	2,952,446
3.04	5.00	ADMINISTRATIVE & GENERAL	AHS HOME OFFICE	4,998,165	3,742,456
3.05	5.00	ADMINISTRATIVE & GENERAL	AHS HOME OFFICE	32,445	0
3.06	1.00	CAP REL COSTS-BLDG & FIXT	AMITA HOME OFFICE	56,268	0
4.00	5.00	ADMINISTRATIVE & GENERAL	AMITA HOME OFFICE	910,977	704,050
4.01	5.00	ADMINISTRATIVE & GENERAL	MIDWEST REGIONAL SHARED SERV	14,448,700	14,448,700
4.02	5.00	ADMINISTRATIVE & GENERAL	HINSDALE SHARED SERVICES	2,171,170	2,171,170
5.00		TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.		33,785,999	30,472,682

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

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

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

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

6.00	B		0.00	ADVENTHEALTH	0.00	6.00
7.00	B		0.00	AMITA HEALTH	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.

	Net Adjustments (col. 4 minus col. 5)*	wkst. A-7 Ref.	
	6.00	7.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	139,965	11	1.00
2.00	465,482	11	2.00
3.00	-2,816	0	3.00
3.01	1,169,572	0	3.01
3.02	703,829	0	3.02
3.03	-714,064	0	3.03
3.04	1,255,709	0	3.04
3.05	32,445	0	3.05
3.06	56,268	11	3.06
4.00	206,927	0	4.00
4.01	0	0	4.01
4.02	0	0	4.02
5.00	3,313,317		5.00

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

	Related Organization(s) and/or Home Office	
	Type of Business	
	6.00	

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	HOME OFFICE		6.00
7.00	HOME OFFICE		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: 14-0304

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

Worksheet A-8-2
Date/Time Prepared:
5/28/2019 6:23 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	46,214	46,214	0	0	0	1.00
2.00	17.00	AGGREGATE-SOCIAL SERVICE	79,909	79,909	0	0	0	2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	27,541	27,541	0	0	0	3.00
4.00	40.00	AGGREGATE-SUBPROVIDER - IPF	12,625	12,625	0	0	0	4.00
5.00	50.00	AGGREGATE-OPERATING ROOM	594	594	0	0	0	5.00
6.00	65.00	AGGREGATE-RESPIRATORY THERAPY	8,061	8,061	0	0	0	6.00
7.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	7,360	7,360	0	0	0	7.00
8.00	76.01	AGGREGATE-WOUND CARE	12,944	12,944	0	0	0	8.00
9.00	90.00	AGGREGATE-CLINIC	6,600	6,600	0	0	0	9.00
10.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	624,000	624,000	0	0	0	10.00
11.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	52,037	52,037	0	0	0	11.00
12.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	249,211	249,211	0	0	0	12.00
13.00	91.00	AGGREGATE-EMERGENCY	35,770	35,770	0	0	0	13.00
200.00			1,162,866	1,162,866	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	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	17.00	AGGREGATE-SOCIAL SERVICE	0	0	0	0	0	2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	0	0	4.00
5.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	5.00
6.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	0	0	6.00
7.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	0	0	0	0	0	7.00
8.00	76.01	AGGREGATE-WOUND CARE	0	0	0	0	0	8.00
9.00	90.00	AGGREGATE-CLINIC	0	0	0	0	0	9.00
10.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	0	0	10.00
11.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	11.00
12.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	0	0	12.00
13.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	13.00
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	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	46,214	1.00
2.00	17.00	AGGREGATE-SOCIAL SERVICE	0	0	0	79,909	2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	27,541	3.00
4.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	12,625	4.00
5.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	594	5.00
6.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	8,061	6.00
7.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	0	0	0	7,360	7.00
8.00	76.01	AGGREGATE-WOUND CARE	0	0	0	12,944	8.00
9.00	90.00	AGGREGATE-CLINIC	0	0	0	6,600	9.00
10.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	624,000	10.00
11.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	52,037	11.00
12.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	249,211	12.00
13.00	91.00	AGGREGATE-EMERGENCY	0	0	0	35,770	13.00
200.00			0	0	0	1,162,866	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0304

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

Worksheet B
Part I
Date/Time Prepared:
5/28/2019 6:23 am

Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	7,303,940	7,303,940			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	3,381,268		3,381,268		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	4,803,388	0	0	4,803,388	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	27,697,705	360,713	166,987	366,787	28,592,192 5.00
7.00 00700	OPERATION OF PLANT	4,981,636	453,170	209,789	158,160	5,802,755 7.00
9.00 00900	HOUSEKEEPING	2,387,886	41,508	19,216	0	2,448,610 9.00
10.00 01000	DIETARY	133,494	218,406	101,108	0	453,008 10.00
11.00 01100	CAFETERIA	1,863,754	81,443	37,703	0	1,982,907 11.00
13.00 01300	NURSING ADMINISTRATION	1,518,492	136,013	62,966	129,202	1,846,673 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	-39,211	144,180	66,746	19,332	191,047 14.00
15.00 01500	PHARMACY	1,917,807	57,118	26,442	206,637	2,208,007 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,014,897	84,940	39,322	33,384	1,172,543 16.00
17.00 01700	SOCIAL SERVICE	676,101	18,007	8,336	76,301	778,745 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	7,964,773	1,550,419	717,747	873,748	11,106,687 30.00
31.00 03100	INTENSIVE CARE UNIT	2,832,326	295,278	136,695	259,471	3,523,770 31.00
40.00 04000	SUBPROVIDER - IPF	2,431,734	367,806	170,271	273,896	3,243,707 40.00
43.00 04300	NURSERY	1,363,929	89,910	41,623	133,592	1,629,054 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	6,379,842	909,911	421,232	464,705	8,175,690 50.00
51.00 05100	RECOVERY ROOM	635,727	88,811	41,114	72,861	838,513 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,515,656	316,607	146,569	202,816	2,181,648 52.00
53.00 05300	ANESTHESIOLOGY	108,623	15,559	7,203	6,269	137,654 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,550,070	576,271	266,778	263,588	3,656,707 54.00
56.00 05600	RADIOISOTOPE	204,940	182,417	84,448	22,682	494,487 56.00
57.00 05700	CT SCAN	864,444	32,667	15,123	76,929	989,163 57.00
58.00 05800	MRI	327,838	22,977	10,637	34,921	396,373 58.00
59.00 05900	CARDIAC CATHETERIZATION	623,261	28,097	13,007	66,291	730,656 59.00
60.00 06000	LABORATORY	2,600,504	99,076	45,866	188,570	2,934,016 60.00
65.00 06500	RESPIRATORY THERAPY	970,380	13,486	6,243	101,573	1,091,682 65.00
66.00 06600	PHYSICAL THERAPY	4,506,990	343,805	159,160	0	5,009,955 66.00
67.00 06700	OCCUPATIONAL THERAPY	62,672	23,826	11,030	0	97,528 67.00
68.00 06800	SPEECH PATHOLOGY	10,944	2,098	971	0	14,013 68.00
69.00 06900	ELECTROCARDIOLOGY	663,903	14,660	6,787	65,899	751,249 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	248,874	34,465	15,955	3,766	303,060 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,016,852	0	0	0	6,016,852 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	5,467,246	0	0	0	5,467,246 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	6,577,842	0	0	0	6,577,842 73.00
74.00 07400	RENAL DIALYSIS	386,801	0	0	0	386,801 74.00
76.00 03020	ANCILLARY	0	0	0	0	0 76.00
76.01 03950	WOUND CARE	4,626	64,935	30,061	634	100,256 76.01
76.97 07697	CARDIAC REHABILITATION	138,195	40,484	18,742	16,373	213,794 76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	1,201,315	190,758	88,309	131,296	1,611,678 90.00
91.00 09100	EMERGENCY	4,257,749	365,933	169,404	475,771	5,268,857 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					0 92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	118,559,213	7,265,754	3,363,590	4,725,454	118,425,415 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	119,263	20,529	9,504	12,480	161,776 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	2,500,983	0	0	0	2,500,983 192.00
194.00 07950	FOUNDATION	140,078	11,813	5,469	13,908	171,268 194.00
194.01 07951	MARKETING	0	0	0	0	0 194.01
194.02 07952	PROF OFFICE BUILDINGS	78,737	0	0	0	78,737 194.02
194.03 07953	OP PHARMACY	1,962,647	5,844	2,705	35,279	2,006,475 194.03
194.04 07954	OTHER NONREIMBURSABLE COST CENTERS	243,766	0	0	16,267	260,033 194.04
200.00	Cross Foot Adjustments					0 200.00
201.00	Negative Cost Centers					0 201.00
202.00	TOTAL (sum lines 118 through 201)	123,604,687	7,303,940	3,381,268	4,803,388	123,604,687 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0304

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

Worksheet B
Part I
Date/Time Prepared:
5/28/2019 6:23 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	
		5.00	7.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	28,592,192					5.00
7.00	00700	1,746,229	7,548,984				7.00
9.00	00900	736,863	48,281	3,233,754			9.00
10.00	01000	136,324	254,041	109,524	952,897		10.00
11.00	01100	596,716	94,732	40,841	718,246	3,433,435	11.00
13.00	01300	555,721	158,206	68,207	0	57,429	13.00
14.00	01400	57,492	167,705	72,302	0	33,849	14.00
15.00	01500	664,457	66,437	28,643	0	107,508	15.00
16.00	01600	352,855	98,799	42,595	0	25,894	16.00
17.00	01700	234,349	20,945	9,030	0	32,887	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	3,342,333	1,803,384	777,486	156,972	905,053	30.00
31.00	03100	1,060,412	343,457	148,073	21,549	197,075	31.00
40.00	04000	976,132	427,817	184,443	56,130	283,530	40.00
43.00	04300	490,233	104,579	45,087	0	116,828	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	2,460,319	1,058,374	456,293	0	272,648	50.00
51.00	05100	252,335	103,301	44,536	0	53,422	51.00
52.00	05200	656,526	368,265	158,769	0	166,627	52.00
53.00	05300	41,424	18,098	7,803	0	4,449	53.00
54.00	05400	1,100,416	670,296	288,983	0	184,067	54.00
56.00	05600	148,806	212,180	91,477	0	20,758	56.00
57.00	05700	297,670	37,997	16,382	0	52,267	57.00
58.00	05800	119,281	26,726	11,522	0	27,282	58.00
59.00	05900	219,877	32,681	14,090	0	65,340	59.00
60.00	06000	882,936	115,241	49,683	0	166,825	60.00
65.00	06500	328,521	15,687	6,763	0	92,874	65.00
66.00	06600	1,507,651	399,900	172,408	0	0	66.00
67.00	06700	29,349	27,714	11,948	0	0	67.00
68.00	06800	4,217	2,440	1,052	0	0	68.00
69.00	06900	226,074	17,052	7,352	0	43,169	69.00
70.00	07000	91,200	40,089	17,283	0	2,155	70.00
71.00	07100	1,810,657	0	0	0	0	71.00
72.00	07200	1,645,264	0	0	0	0	72.00
73.00	07300	1,979,477	0	0	0	0	73.00
74.00	07400	116,400	0	0	0	0	74.00
76.00	03020	0	0	0	0	0	76.00
76.01	03950	30,170	75,530	32,563	0	294	76.01
76.97	07697	64,337	47,090	20,302	0	7,985	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	485,004	221,883	95,660	0	64,072	90.00
91.00	09100	1,585,562	425,639	183,504	0	424,408	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		27,033,589	7,504,566	3,214,604	952,897	3,408,695	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	48,683	23,879	10,295	0	8,033	190.00
192.00	19200	752,623	0	0	0	0	192.00
194.00	07950	51,540	13,741	5,924	0	4,697	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	23,694	0	0	0	0	194.02
194.03	07953	603,811	6,798	2,931	0	12,010	194.03
194.04	07954	78,252	0	0	0	0	194.04
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		28,592,192	7,548,984	3,233,754	952,897	3,433,435	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0304

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

Worksheet B
Part I
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Cost Center Description		NURSING	CENTRAL	PHARMACY	MEDICAL	SOCIAL SERVICE	
		ADMINISTRATION	SERVICES & SUPPLY		RECORDS & LIBRARY		
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	2,686,236					13.00
14.00	01400	0	522,395				14.00
15.00	01500	0	4,292	3,079,341			15.00
16.00	01600	0	0	0	1,692,706		16.00
17.00	01700	0	0	0	0	1,075,956	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	977,032	21,277	334	106,877	580,460	30.00
31.00	03100	212,748	30,612	99	17,357	79,682	31.00
40.00	04000	306,079	4,275	10	30,598	207,558	40.00
43.00	04300	126,120	2,773	1	11,580	95,393	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	294,332	193,662	8,853	167,032	0	50.00
51.00	05100	57,670	1,285	11	18,671	0	51.00
52.00	05200	179,879	16,324	589	12,663	0	52.00
53.00	05300	5,047	8,461	58,849	45,740	0	53.00
54.00	05400	0	6,047	82	139,978	0	54.00
56.00	05600	0	0	0	17,175	0	56.00
57.00	05700	0	7,532	1	174,397	0	57.00
58.00	05800	0	488	255	39,764	0	58.00
59.00	05900	0	47,676	15	18,110	0	59.00
60.00	06000	0	59,184	5	178,806	0	60.00
65.00	06500	0	5,787	0	33,685	0	65.00
66.00	06600	0	0	0	48,268	0	66.00
67.00	06700	0	0	0	3,586	0	67.00
68.00	06800	0	0	0	987	0	68.00
69.00	06900	0	739	1	49,892	0	69.00
70.00	07000	0	38	0	8,666	0	70.00
71.00	07100	0	53,027	0	38,791	0	71.00
72.00	07200	0	0	0	78,963	0	72.00
73.00	07300	0	0	2,308,268	169,947	0	73.00
74.00	07400	0	0	0	3,806	0	74.00
76.00	03020	0	0	0	0	0	76.00
76.01	03950	0	421	0	28	0	76.01
76.97	07697	0	116	0	2,067	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	69,168	3,339	0	21,341	0	90.00
91.00	09100	458,161	54,998	628	253,931	112,863	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		2,686,236	522,373	2,378,001	1,692,706	1,075,956	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	22	701,340	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		2,686,236	522,395	3,079,341	1,692,706	1,075,956	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0304

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

Worksheet B
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
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
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	19,777,895	0	19,777,895
31.00	03100	INTENSIVE CARE UNIT	5,634,834	0	5,634,834
40.00	04000	SUBPROVIDER - IPF	5,720,279	0	5,720,279
43.00	04300	NURSERY	2,621,648	0	2,621,648
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	13,087,203	0	13,087,203
51.00	05100	RECOVERY ROOM	1,369,744	0	1,369,744
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,741,290	0	3,741,290
53.00	05300	ANESTHESIOLOGY	327,525	0	327,525
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,046,576	0	6,046,576
56.00	05600	RADIOISOTOPE	984,883	0	984,883
57.00	05700	CT SCAN	1,575,409	0	1,575,409
58.00	05800	MRI	621,691	0	621,691
59.00	05900	CARDIAC CATHETERIZATION	1,128,445	0	1,128,445
60.00	06000	LABORATORY	4,386,696	0	4,386,696
65.00	06500	RESPIRATORY THERAPY	1,574,999	0	1,574,999
66.00	06600	PHYSICAL THERAPY	7,138,182	0	7,138,182
67.00	06700	OCCUPATIONAL THERAPY	170,125	0	170,125
68.00	06800	SPEECH PATHOLOGY	22,709	0	22,709
69.00	06900	ELECTROCARDIOLOGY	1,095,528	0	1,095,528
70.00	07000	ELECTROENCEPHALOGRAPHY	462,491	0	462,491
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,919,327	0	7,919,327
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,191,473	0	7,191,473
73.00	07300	DRUGS CHARGED TO PATIENTS	11,035,534	0	11,035,534
74.00	07400	RENAL DIALYSIS	507,007	0	507,007
76.00	03020	ANCILLARY	0	0	0
76.01	03950	WOUND CARE	239,262	0	239,262
76.97	07697	CARDIAC REHABILITATION	355,691	0	355,691
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	2,572,145	0	2,572,145
91.00	09100	EMERGENCY	8,768,551	0	8,768,551
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	116,077,142	0	116,077,142
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	252,666	0	252,666
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,253,606	0	3,253,606
194.00	07950	FOUNDATION	247,170	0	247,170
194.01	07951	MARKETING	0	0	0
194.02	07952	PROF OFFICE BUILDINGS	102,431	0	102,431
194.03	07953	OP PHARMACY	3,333,387	0	3,333,387
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	338,285	0	338,285
200.00		Cross Foot Adjustments	0	0	0
201.00		Negative Cost Centers	0	0	0
202.00		TOTAL (sum lines 118 through 201)	123,604,687	0	123,604,687

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0304

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

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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	2A	4.00
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	360,713	166,987	527,700
7.00	00700	OPERATION OF PLANT	0	453,170	209,789	662,959
9.00	00900	HOUSEKEEPING	0	41,508	19,216	60,724
10.00	01000	DIETARY	0	218,406	101,108	319,514
11.00	01100	CAFETERIA	0	81,443	37,703	119,146
13.00	01300	NURSING ADMINISTRATION	0	136,013	62,966	198,979
14.00	01400	CENTRAL SERVICES & SUPPLY	0	144,180	66,746	210,926
15.00	01500	PHARMACY	0	57,118	26,442	83,560
16.00	01600	MEDICAL RECORDS & LIBRARY	0	84,940	39,322	124,262
17.00	01700	SOCIAL SERVICE	0	18,007	8,336	26,343
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,550,419	717,747	2,268,166
31.00	03100	INTENSIVE CARE UNIT	0	295,278	136,695	431,973
40.00	04000	SUBPROVIDER - IPF	0	367,806	170,271	538,077
43.00	04300	NURSERY	0	89,910	41,623	131,533
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	909,911	421,232	1,331,143
51.00	05100	RECOVERY ROOM	0	88,811	41,114	129,925
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	316,607	146,569	463,176
53.00	05300	ANESTHESIOLOGY	0	15,559	7,203	22,762
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	576,271	266,778	843,049
56.00	05600	RADIOISOTOPE	0	182,417	84,448	266,865
57.00	05700	CT SCAN	0	32,667	15,123	47,790
58.00	05800	MRI	0	22,977	10,637	33,614
59.00	05900	CARDIAC CATHETERIZATION	0	28,097	13,007	41,104
60.00	06000	LABORATORY	0	99,076	45,866	144,942
65.00	06500	RESPIRATORY THERAPY	0	13,486	6,243	19,729
66.00	06600	PHYSICAL THERAPY	0	343,805	159,160	502,965
67.00	06700	OCCUPATIONAL THERAPY	0	23,826	11,030	34,856
68.00	06800	SPEECH PATHOLOGY	0	2,098	971	3,069
69.00	06900	ELECTROCARDIOLOGY	0	14,660	6,787	21,447
70.00	07000	ELECTROENCEPHALOGRAPHY	0	34,465	15,955	50,420
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
76.00	03020	ANCILLARY	0	0	0	0
76.01	03950	WOUND CARE	0	64,935	30,061	94,996
76.97	07697	CARDIAC REHABILITATION	0	40,484	18,742	59,226
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	190,758	88,309	279,067
91.00	09100	EMERGENCY	0	365,933	169,404	535,337
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	7,265,754	3,363,590	10,629,344
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	20,529	9,504	30,033
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0
194.00	07950	FOUNDATION	0	11,813	5,469	17,282
194.01	07951	MARKETING	0	0	0	0
194.02	07952	PROF OFFICE BUILDINGS	0	0	0	0
194.03	07953	OP PHARMACY	0	5,844	2,705	8,549
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0
200.00		Cross Foot Adjustments				0
201.00		Negative Cost Centers				0
202.00		TOTAL (sum lines 118 through 201)	0	7,303,940	3,381,268	10,685,208

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0304

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA		
		5.00	7.00	9.00	10.00	11.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	527,700				5.00	
7.00	00700	OPERATION OF PLANT	32,229	695,188			7.00	
9.00	00900	HOUSEKEEPING	13,600	4,446	78,770		9.00	
10.00	01000	DIETARY	2,516	23,395	2,668	348,093	10.00	
11.00	01100	CAFETERIA	11,013	8,724	995	262,375	402,253	11.00
13.00	01300	NURSING ADMINISTRATION	10,256	14,569	1,661	0	6,728	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,061	15,444	1,761	0	3,966	14.00
15.00	01500	PHARMACY	12,263	6,118	698	0	12,595	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,512	9,098	1,038	0	3,034	16.00
17.00	01700	SOCIAL SERVICE	4,325	1,929	220	0	3,853	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	61,689	166,072	18,938	57,342	106,034	30.00
31.00	03100	INTENSIVE CARE UNIT	19,571	31,629	3,607	7,872	23,089	31.00
40.00	04000	SUBPROVIDER - IPF	18,016	39,398	4,493	20,504	33,218	40.00
43.00	04300	NURSERY	9,048	9,631	1,098	0	13,687	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	45,408	97,466	11,115	0	31,943	50.00
51.00	05100	RECOVERY ROOM	4,657	9,513	1,085	0	6,259	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,117	33,914	3,867	0	19,522	52.00
53.00	05300	ANESTHESIOLOGY	765	1,667	190	0	521	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,309	61,728	7,039	0	21,565	54.00
56.00	05600	RADIOISOTOPE	2,746	19,540	2,228	0	2,432	56.00
57.00	05700	CT SCAN	5,494	3,499	399	0	6,123	57.00
58.00	05800	MRI	2,201	2,461	281	0	3,196	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,058	3,010	343	0	7,655	59.00
60.00	06000	LABORATORY	16,296	10,613	1,210	0	19,545	60.00
65.00	06500	RESPIRATORY THERAPY	6,063	1,445	165	0	10,881	65.00
66.00	06600	PHYSICAL THERAPY	27,825	36,827	4,200	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	542	2,552	291	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	78	225	26	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,172	1,570	179	0	5,058	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,683	3,692	421	0	252	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	33,418	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,365	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	36,533	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,148	0	0	0	0	74.00
76.00	03020	ANCILLARY	0	0	0	0	0	76.00
76.01	03950	WOUND CARE	557	6,956	793	0	34	76.01
76.97	07697	CARDIAC REHABILITATION	1,187	4,337	495	0	935	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	8,951	20,433	2,330	0	7,507	90.00
91.00	09100	EMERGENCY	29,263	39,197	4,470	0	49,723	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	498,935	691,098	78,304	348,093	399,355	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	899	2,199	251	0	941	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,890	0	0	0	0	192.00
194.00	07950	FOUNDATION	951	1,265	144	0	550	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	PROF OFFICE BUILDINGS	437	0	0	0	0	194.02
194.03	07953	OP PHARMACY	11,144	626	71	0	1,407	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	1,444	0	0	0	0	194.04
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)	527,700	695,188	78,770	348,093	402,253	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0304

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

worksheet B
Part II
Date/Time Prepared:
5/28/2019 6:23 am

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	232,193					13.00
14.00	01400	0	216,879				14.00
15.00	01500	0	1,782	117,016			15.00
16.00	01600	0	8	0	143,952		16.00
17.00	01700	0	0	0	0	36,670	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	84,452	8,833	13	9,088	19,782	30.00
31.00	03100	18,390	12,709	4	1,476	2,716	31.00
40.00	04000	26,457	1,775	0	2,602	7,074	40.00
43.00	04300	10,902	1,151	0	985	3,251	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	25,441	80,402	336	14,203	0	50.00
51.00	05100	4,985	533	0	1,588	0	51.00
52.00	05200	15,548	6,777	22	1,077	0	52.00
53.00	05300	436	3,513	2,236	3,889	0	53.00
54.00	05400	0	2,511	3	11,903	0	54.00
56.00	05600	0	0	0	1,460	0	56.00
57.00	05700	0	3,127	0	14,829	0	57.00
58.00	05800	0	202	10	3,381	0	58.00
59.00	05900	0	19,793	1	1,540	0	59.00
60.00	06000	0	24,571	0	15,204	0	60.00
65.00	06500	0	2,403	0	2,864	0	65.00
66.00	06600	0	0	0	4,104	0	66.00
67.00	06700	0	0	0	305	0	67.00
68.00	06800	0	0	0	84	0	68.00
69.00	06900	0	307	0	4,242	0	69.00
70.00	07000	0	16	0	737	0	70.00
71.00	07100	0	22,015	0	3,298	0	71.00
72.00	07200	0	0	0	6,714	0	72.00
73.00	07300	0	0	87,716	14,451	0	73.00
74.00	07400	0	0	0	324	0	74.00
76.00	03020	0	0	0	0	0	76.00
76.01	03950	0	175	0	2	0	76.01
76.97	07697	0	48	0	176	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	5,979	1,386	0	1,815	0	90.00
91.00	09100	39,603	22,833	24	21,611	3,847	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		232,193	216,870	90,365	143,952	36,670	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	9	26,651	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
200.00							200.00
201.00		0	16,279	0	0	0	201.00
202.00		232,193	233,158	117,016	143,952	36,670	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0304

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

Worksheet B
Part II
Date/Time Prepared:
5/28/2019 6:23 am

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
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
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,800,409	0	2,800,409
31.00	03100	INTENSIVE CARE UNIT	553,036	0	553,036
40.00	04000	SUBPROVIDER - IPF	691,614	0	691,614
43.00	04300	NURSERY	181,286	0	181,286
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,637,457	0	1,637,457
51.00	05100	RECOVERY ROOM	158,545	0	158,545
52.00	05200	DELIVERY ROOM & LABOR ROOM	556,020	0	556,020
53.00	05300	ANESTHESIOLOGY	35,979	0	35,979
54.00	05400	RADIOLOGY-DIAGNOSTIC	968,107	0	968,107
56.00	05600	RADIOISOTOPE	295,271	0	295,271
57.00	05700	CT SCAN	81,261	0	81,261
58.00	05800	MRI	45,346	0	45,346
59.00	05900	CARDIAC CATHETERIZATION	77,504	0	77,504
60.00	06000	LABORATORY	232,381	0	232,381
65.00	06500	RESPIRATORY THERAPY	43,550	0	43,550
66.00	06600	PHYSICAL THERAPY	575,921	0	575,921
67.00	06700	OCCUPATIONAL THERAPY	38,546	0	38,546
68.00	06800	SPEECH PATHOLOGY	3,482	0	3,482
69.00	06900	ELECTROCARDIOLOGY	36,975	0	36,975
70.00	07000	ELECTROENCEPHALOGRAPHY	57,221	0	57,221
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	58,731	0	58,731
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	37,079	0	37,079
73.00	07300	DRUGS CHARGED TO PATIENTS	138,700	0	138,700
74.00	07400	RENAL DIALYSIS	2,472	0	2,472
76.00	03020	ANCILLARY	0	0	0
76.01	03950	WOUND CARE	103,513	0	103,513
76.97	07697	CARDIAC REHABILITATION	66,404	0	66,404
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	327,468	0	327,468
91.00	09100	EMERGENCY	745,908	0	745,908
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,550,186	0	10,550,186
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	34,323	0	34,323
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,890	0	13,890
194.00	07950	FOUNDATION	20,192	0	20,192
194.01	07951	MARKETING	0	0	0
194.02	07952	PROF OFFICE BUILDINGS	437	0	437
194.03	07953	OP PHARMACY	48,457	0	48,457
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	1,444	0	1,444
200.00		Cross Foot Adjustments	0	0	0
201.00		Negative Cost Centers	16,279	0	16,279
202.00		TOTAL (sum lines 118 through 201)	10,685,208	0	10,685,208

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	292,451				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		292,451			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	38,781,263		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	14,443	14,443	2,961,349	-28,592,192	5.00
7.00 00700	OPERATION OF PLANT	18,145	18,145	1,276,946	0	7.00
9.00 00900	HOUSEKEEPING	1,662	1,662	0	0	9.00
10.00 01000	DIETARY	8,745	8,745	0	0	10.00
11.00 01100	CAFETERIA	3,261	3,261	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	5,446	5,446	1,043,143	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	5,773	5,773	156,083	0	14.00
15.00 01500	PHARMACY	2,287	2,287	1,668,341	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	3,401	3,401	269,538	0	16.00
17.00 01700	SOCIAL SERVICE	721	721	616,034	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	62,079	62,079	7,054,280	0	30.00
31.00 03100	INTENSIVE CARE UNIT	11,823	11,823	2,094,911	0	31.00
40.00 04000	SUBPROVIDER - IPF	14,727	14,727	2,211,369	0	40.00
43.00 04300	NURSERY	3,600	3,600	1,078,591	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	36,433	36,433	3,751,919	0	50.00
51.00 05100	RECOVERY ROOM	3,556	3,556	588,262	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	12,677	12,677	1,637,490	0	52.00
53.00 05300	ANESTHESIOLOGY	623	623	50,618	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	23,074	23,074	2,128,147	0	54.00
56.00 05600	RADIOISOTOPE	7,304	7,304	183,126	0	56.00
57.00 05700	CT SCAN	1,308	1,308	621,108	0	57.00
58.00 05800	MRI	920	920	281,947	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	1,125	1,125	535,216	0	59.00
60.00 06000	LABORATORY	3,967	3,967	1,522,466	0	60.00
65.00 06500	RESPIRATORY THERAPY	540	540	820,074	0	65.00
66.00 06600	PHYSICAL THERAPY	13,766	13,766	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	954	954	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	84	84	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	587	587	532,055	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	1,380	1,380	30,402	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
76.00 03020	ANCILLARY	0	0	0	0	76.00
76.01 03950	WOUND CARE	2,600	2,600	5,118	0	76.01
76.97 07697	CARDIAC REHABILITATION	1,621	1,621	132,191	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	7,638	7,638	1,060,054	0	90.00
91.00 09100	EMERGENCY	14,652	14,652	3,841,262	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	290,922	290,922	38,152,040	-28,592,192	89,833,223 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	822	822	100,761	0	161,776 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	2,500,983 192.00
194.00 07950	FOUNDATION	473	473	112,290	0	171,268 194.00
194.01 07951	MARKETING	0	0	0	0	0 194.01
194.02 07952	PROF OFFICE BUILDINGS	0	0	0	0	78,737 194.02
194.03 07953	OP PHARMACY	234	234	284,833	0	2,006,475 194.03
194.04 07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	131,339	0	260,033 194.04
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)	7,303,940	3,381,268	4,803,388		28,592,192 202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	24.974919	11.561827	0.123858		0.300931 203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0		527,700 204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.005554 205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0304

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

Worksheet B-1
Date/Time Prepared:
5/28/2019 6:23 am

Cost Center Description	CAPITAL RELATED COSTS			Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)			
	1.00	2.00	4.00			
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)				5A	5.00	207.00

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (TOTAL HOURS)	NURSING ADMINISTRATION (TOTAL HOURS)	
		7.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	259,863				7.00
9.00	00900	HOUSEKEEPING	1,662	258,201			9.00
10.00	01000	DIETARY	8,745	8,745	408,865		10.00
11.00	01100	CAFETERIA	3,261	3,261	308,182	1,578,937	11.00
13.00	01300	NURSING ADMINISTRATION	5,446	5,446	0	26,410	1,144,315
14.00	01400	CENTRAL SERVICES & SUPPLY	5,773	5,773	0	15,566	0
15.00	01500	PHARMACY	2,287	2,287	0	49,440	0
16.00	01600	MEDICAL RECORDS & LIBRARY	3,401	3,401	0	11,908	0
17.00	01700	SOCIAL SERVICE	721	721	0	15,124	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	62,079	62,079	67,353	416,208	416,208
31.00	03100	INTENSIVE CARE UNIT	11,823	11,823	9,246	90,629	90,629
40.00	04000	SUBPROVIDER - IPF	14,727	14,727	24,084	130,387	130,387
43.00	04300	NURSERY	3,600	3,600	0	53,726	53,726
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	36,433	36,433	0	125,383	125,383
51.00	05100	RECOVERY ROOM	3,556	3,556	0	24,567	24,567
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,677	12,677	0	76,627	76,627
53.00	05300	ANESTHESIOLOGY	623	623	0	2,046	2,150
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,074	23,074	0	84,647	0
56.00	05600	RADIOISOTOPE	7,304	7,304	0	9,546	0
57.00	05700	CT SCAN	1,308	1,308	0	24,036	0
58.00	05800	MRI	920	920	0	12,546	0
59.00	05900	CARDIAC CATHETERIZATION	1,125	1,125	0	30,048	0
60.00	06000	LABORATORY	3,967	3,967	0	76,718	0
65.00	06500	RESPIRATORY THERAPY	540	540	0	42,710	0
66.00	06600	PHYSICAL THERAPY	13,766	13,766	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	954	954	0	0	0
68.00	06800	SPEECH PATHOLOGY	84	84	0	0	0
69.00	06900	ELECTROCARDIOLOGY	587	587	0	19,852	0
70.00	07000	ELECTROENCEPHALOGRAPHY	1,380	1,380	0	991	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
76.00	03020	ANCILLARY	0	0	0	0	0
76.01	03950	WOUND CARE	2,600	2,600	0	135	0
76.97	07697	CARDIAC REHABILITATION	1,621	1,621	0	3,672	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	7,638	7,638	0	29,465	29,465
91.00	09100	EMERGENCY	14,652	14,652	0	195,173	195,173
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	258,334	256,672	408,865	1,567,560	1,144,315
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	822	822	0	3,694	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	FOUNDATION	473	473	0	2,160	0
194.01	07951	MARKETING	0	0	0	0	0
194.02	07952	PROF OFFICE BUILDINGS	0	0	0	0	0
194.03	07953	OP PHARMACY	234	234	0	5,523	0
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
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)	7,548,984	3,233,754	952,897	3,433,435	2,686,236
203.00		Unit cost multiplier (Wkst. B, Part I)	29.049861	12.524173	2.330591	2.174523	2.347462
204.00		Cost to be allocated (per Wkst. B, Part II)	695,188	78,770	348,093	402,253	232,193
205.00		Unit cost multiplier (Wkst. B, Part II)	2.675210	0.305072	0.851364	0.254762	0.202910
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 Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	
		14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300					13.00
14.00	01400	5,539,953				14.00
15.00	01500	45,519	7,250,813			15.00
16.00	01600	212	0	539,034,898		16.00
17.00	01700	0	0	0	32,394	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	225,641	786	34,037,309	17,476	30.00
31.00	03100	324,634	234	5,527,612	2,399	31.00
40.00	04000	45,333	23	9,744,683	6,249	40.00
43.00	04300	29,411	3	3,687,859	2,872	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	2,053,771	20,847	53,195,009	0	50.00
51.00	05100	13,625	25	5,946,186	0	51.00
52.00	05200	173,117	1,386	4,032,755	0	52.00
53.00	05300	89,727	138,569	14,566,766	0	53.00
54.00	05400	64,129	192	44,579,023	0	54.00
56.00	05600	0	0	5,469,712	0	56.00
57.00	05700	79,880	2	55,540,522	0	57.00
58.00	05800	5,172	600	12,663,693	0	58.00
59.00	05900	505,600	35	5,767,629	0	59.00
60.00	06000	627,641	11	56,944,454	0	60.00
65.00	06500	61,374	0	10,727,725	0	65.00
66.00	06600	0	0	15,371,971	0	66.00
67.00	06700	0	0	1,141,906	0	67.00
68.00	06800	0	0	314,416	0	68.00
69.00	06900	7,834	3	15,889,014	0	69.00
70.00	07000	404	0	2,759,815	0	70.00
71.00	07100	562,350	0	12,353,714	0	71.00
72.00	07200	0	0	25,147,488	0	72.00
73.00	07300	0	5,435,198	54,123,359	0	73.00
74.00	07400	0	0	1,211,995	0	74.00
76.00	03020	0	0	0	0	76.00
76.01	03950	4,463	0	8,900	0	76.01
76.97	07697	1,228	0	658,282	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	35,405	0	6,796,643	0	90.00
91.00	09100	583,252	1,479	80,826,458	3,398	91.00
92.00	09200					92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300					113.00
118.00		5,539,722	5,599,393	539,034,898	32,394	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	0	0	0	190.00
192.00	19200	0	0	0	0	192.00
194.00	07950	0	0	0	0	194.00
194.01	07951	0	0	0	0	194.01
194.02	07952	0	0	0	0	194.02
194.03	07953	231	1,651,420	0	0	194.03
194.04	07954	0	0	0	0	194.04
200.00						200.00
201.00						201.00
202.00		522,395	3,079,341	1,692,706	1,075,956	202.00
203.00		0.094296	0.424689	0.003140	33.214669	203.00
204.00		233,158	117,016	143,952	36,670	204.00
205.00		0.039148	0.016138	0.000267	1.132000	205.00
206.00						206.00
207.00						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0304

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

Worksheet C
Part I
Date/Time Prepared:
5/28/2019 6:23 am

Cost Center Description		Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XVIII		Hospital		PPS
				Total Costs	RCE Disallowance	Total Costs		
								Costs
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	19,777,895		19,777,895	0	19,777,895	30.00
31.00	03100	INTENSIVE CARE UNIT	5,634,834		5,634,834	0	5,634,834	31.00
40.00	04000	SUBPROVIDER - IPF	5,720,279		5,720,279	0	5,720,279	40.00
43.00	04300	NURSERY	2,621,648		2,621,648	0	2,621,648	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	13,087,203		13,087,203	0	13,087,203	50.00
51.00	05100	RECOVERY ROOM	1,369,744		1,369,744	0	1,369,744	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,741,290		3,741,290	0	3,741,290	52.00
53.00	05300	ANESTHESIOLOGY	327,525		327,525	0	327,525	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,046,576		6,046,576	0	6,046,576	54.00
56.00	05600	RADIOISOTOPE	984,883		984,883	0	984,883	56.00
57.00	05700	CT SCAN	1,575,409		1,575,409	0	1,575,409	57.00
58.00	05800	MRI	621,691		621,691	0	621,691	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,128,445		1,128,445	0	1,128,445	59.00
60.00	06000	LABORATORY	4,386,696		4,386,696	0	4,386,696	60.00
65.00	06500	RESPIRATORY THERAPY	1,574,999	0	1,574,999	0	1,574,999	65.00
66.00	06600	PHYSICAL THERAPY	7,138,182	0	7,138,182	0	7,138,182	66.00
67.00	06700	OCCUPATIONAL THERAPY	170,125	0	170,125	0	170,125	67.00
68.00	06800	SPEECH PATHOLOGY	22,709	0	22,709	0	22,709	68.00
69.00	06900	ELECTROCARDIOLOGY	1,095,528		1,095,528	0	1,095,528	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	462,491		462,491	0	462,491	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,919,327		7,919,327	0	7,919,327	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,191,473		7,191,473	0	7,191,473	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,035,534		11,035,534	0	11,035,534	73.00
74.00	07400	RENAL DIALYSIS	507,007		507,007	0	507,007	74.00
76.00	03020	ANCILLARY	0		0	0	0	76.00
76.01	03950	WOUND CARE	239,262		239,262	0	239,262	76.01
76.97	07697	CARDIAC REHABILITATION	355,691		355,691	0	355,691	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,572,145		2,572,145	0	2,572,145	90.00
91.00	09100	EMERGENCY	8,768,551		8,768,551	0	8,768,551	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,219,571		3,219,571	0	3,219,571	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	119,296,713	0	119,296,713	0	119,296,713	200.00
201.00		Less Observation Beds	3,219,571		3,219,571		3,219,571	201.00
202.00		Total (see instructions)	116,077,142	0	116,077,142	0	116,077,142	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0304

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

Worksheet C
Part I
Date/Time Prepared:
5/28/2019 6:23 am

Cost Center Description	Title XVIII			Hospital	PPS			
	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
6.00	7.00	8.00	9.00	10.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	26,453,140		26,453,140		30.00	
31.00	03100	INTENSIVE CARE UNIT	5,527,612		5,527,612		31.00	
40.00	04000	SUBPROVIDER - IPF	9,744,683		9,744,683		40.00	
43.00	04300	NURSERY	3,687,859		3,687,859		43.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,330,326	41,864,683	53,195,009	0.246023	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,657,340	4,288,846	5,946,186	0.230357	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,105,224	927,531	4,032,755	0.927726	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	4,107,170	10,459,596	14,566,766	0.022484	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,006,302	36,572,721	44,579,023	0.135637	0.000000	54.00
56.00	05600	RADIOISOTOPE	1,156,452	4,313,260	5,469,712	0.180061	0.000000	56.00
57.00	05700	CT SCAN	14,364,976	41,175,546	55,540,522	0.028365	0.000000	57.00
58.00	05800	MRI	2,469,982	10,193,711	12,663,693	0.049092	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,385,654	1,381,975	5,767,629	0.195651	0.000000	59.00
60.00	06000	LABORATORY	27,354,036	29,590,418	56,944,454	0.077035	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	9,398,090	1,329,635	10,727,725	0.146816	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,048,426	13,323,545	15,371,971	0.464363	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	996,675	145,231	1,141,906	0.148983	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	262,065	52,351	314,416	0.072226	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	5,855,312	10,033,702	15,889,014	0.068949	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	151,154	2,608,661	2,759,815	0.167580	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,104,284	8,249,430	12,353,714	0.641048	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,881,354	18,266,134	25,147,488	0.285972	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,542,943	31,580,416	54,123,359	0.203896	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,211,995	0	1,211,995	0.418324	0.000000	74.00
76.00	03020	ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03950	WOUND CARE	0	8,900	8,900	26.883371	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	10,878	647,404	658,282	0.540332	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	49,863	6,746,780	6,796,643	0.378443	0.000000	90.00
91.00	09100	EMERGENCY	16,302,133	64,524,325	80,826,458	0.108486	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,517,784	6,066,385	7,584,169	0.424512	0.000000	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	194,683,712	344,351,186	539,034,898			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	194,683,712	344,351,186	539,034,898			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0304

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

Worksheet C
Part I
Date/Time Prepared:
5/28/2019 6:23 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
40.00	04000 SUBPROVIDER - IPF				40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.246023			50.00
51.00	05100 RECOVERY ROOM	0.230357			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.927726			52.00
53.00	05300 ANESTHESIOLOGY	0.022484			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.135637			54.00
56.00	05600 RADIOISOTOPE	0.180061			56.00
57.00	05700 CT SCAN	0.028365			57.00
58.00	05800 MRI	0.049092			58.00
59.00	05900 CARDIAC CATHETERIZATION	0.195651			59.00
60.00	06000 LABORATORY	0.077035			60.00
65.00	06500 RESPIRATORY THERAPY	0.146816			65.00
66.00	06600 PHYSICAL THERAPY	0.464363			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.148983			67.00
68.00	06800 SPEECH PATHOLOGY	0.072226			68.00
69.00	06900 ELECTROCARDIOLOGY	0.068949			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.167580			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.641048			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.285972			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.203896			73.00
74.00	07400 RENAL DIALYSIS	0.418324			74.00
76.00	03020 ANCILLARY	0.000000			76.00
76.01	03950 WOUND CARE	26.883371			76.01
76.97	07697 CARDIAC REHABILITATION	0.540332			76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.378443			90.00
91.00	09100 EMERGENCY	0.108486			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.424512			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0304

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

Worksheet C
Part I
Date/Time Prepared:
5/28/2019 6:23 am

Cost Center Description		Title XIX			Hospital		Cost	
		Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs			
					RCE Disallowance	Total Costs		
1.00	2.00	3.00	4.00	5.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	19,777,895		19,777,895	0	19,777,895	30.00
31.00	03100	INTENSIVE CARE UNIT	5,634,834		5,634,834	0	5,634,834	31.00
40.00	04000	SUBPROVIDER - IPF	5,720,279		5,720,279	0	5,720,279	40.00
43.00	04300	NURSERY	2,621,648		2,621,648	0	2,621,648	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	13,087,203		13,087,203	0	13,087,203	50.00
51.00	05100	RECOVERY ROOM	1,369,744		1,369,744	0	1,369,744	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,741,290		3,741,290	0	3,741,290	52.00
53.00	05300	ANESTHESIOLOGY	327,525		327,525	0	327,525	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,046,576		6,046,576	0	6,046,576	54.00
56.00	05600	RADIOISOTOPE	984,883		984,883	0	984,883	56.00
57.00	05700	CT SCAN	1,575,409		1,575,409	0	1,575,409	57.00
58.00	05800	MRI	621,691		621,691	0	621,691	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,128,445		1,128,445	0	1,128,445	59.00
60.00	06000	LABORATORY	4,386,696		4,386,696	0	4,386,696	60.00
65.00	06500	RESPIRATORY THERAPY	1,574,999	0	1,574,999	0	1,574,999	65.00
66.00	06600	PHYSICAL THERAPY	7,138,182	0	7,138,182	0	7,138,182	66.00
67.00	06700	OCCUPATIONAL THERAPY	170,125	0	170,125	0	170,125	67.00
68.00	06800	SPEECH PATHOLOGY	22,709	0	22,709	0	22,709	68.00
69.00	06900	ELECTROCARDIOLOGY	1,095,528		1,095,528	0	1,095,528	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	462,491		462,491	0	462,491	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,919,327		7,919,327	0	7,919,327	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,191,473		7,191,473	0	7,191,473	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,035,534		11,035,534	0	11,035,534	73.00
74.00	07400	RENAL DIALYSIS	507,007		507,007	0	507,007	74.00
76.00	03020	ANCILLARY	0		0	0	0	76.00
76.01	03950	WOUND CARE	239,262		239,262	0	239,262	76.01
76.97	07697	CARDIAC REHABILITATION	355,691		355,691	0	355,691	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,572,145		2,572,145	0	2,572,145	90.00
91.00	09100	EMERGENCY	8,768,551		8,768,551	0	8,768,551	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,219,571		3,219,571	0	3,219,571	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	119,296,713	0	119,296,713	0	119,296,713	200.00
201.00		Less Observation Beds	3,219,571		3,219,571		3,219,571	201.00
202.00		Total (see instructions)	116,077,142	0	116,077,142	0	116,077,142	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0304

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

Worksheet C
Part I
Date/Time Prepared:
5/28/2019 6:23 am

Cost Center Description	Title XIX			Hospital	Cost			
	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
6.00	7.00	8.00	9.00	10.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	26,453,140		26,453,140	30.00		
31.00	03100	INTENSIVE CARE UNIT	5,527,612		5,527,612	31.00		
40.00	04000	SUBPROVIDER - IPF	9,744,683		9,744,683	40.00		
43.00	04300	NURSERY	3,687,859		3,687,859	43.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,330,326	41,864,683	53,195,009	0.246023	0.246023	50.00
51.00	05100	RECOVERY ROOM	1,657,340	4,288,846	5,946,186	0.230357	0.230357	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,105,224	927,531	4,032,755	0.927726	0.927726	52.00
53.00	05300	ANESTHESIOLOGY	4,107,170	10,459,596	14,566,766	0.022484	0.022484	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,006,302	36,572,721	44,579,023	0.135637	0.135637	54.00
56.00	05600	RADIOISOTOPE	1,156,452	4,313,260	5,469,712	0.180061	0.180061	56.00
57.00	05700	CT SCAN	14,364,976	41,175,546	55,540,522	0.028365	0.028365	57.00
58.00	05800	MRI	2,469,982	10,193,711	12,663,693	0.049092	0.049092	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,385,654	1,381,975	5,767,629	0.195651	0.195651	59.00
60.00	06000	LABORATORY	27,354,036	29,590,418	56,944,454	0.077035	0.077035	60.00
65.00	06500	RESPIRATORY THERAPY	9,398,090	1,329,635	10,727,725	0.146816	0.146816	65.00
66.00	06600	PHYSICAL THERAPY	2,048,426	13,323,545	15,371,971	0.464363	0.464363	66.00
67.00	06700	OCCUPATIONAL THERAPY	996,675	145,231	1,141,906	0.148983	0.148983	67.00
68.00	06800	SPEECH PATHOLOGY	262,065	52,351	314,416	0.072226	0.072226	68.00
69.00	06900	ELECTROCARDIOLOGY	5,855,312	10,033,702	15,889,014	0.068949	0.068949	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	151,154	2,608,661	2,759,815	0.167580	0.167580	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,104,284	8,249,430	12,353,714	0.641048	0.641048	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,881,354	18,266,134	25,147,488	0.285972	0.285972	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,542,943	31,580,416	54,123,359	0.203896	0.203896	73.00
74.00	07400	RENAL DIALYSIS	1,211,995	0	1,211,995	0.418324	0.418324	74.00
76.00	03020	ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03950	WOUND CARE	0	8,900	8,900	26.883371	26.883371	76.01
76.97	07697	CARDIAC REHABILITATION	10,878	647,404	658,282	0.540332	0.540332	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	49,863	6,746,780	6,796,643	0.378443	0.378443	90.00
91.00	09100	EMERGENCY	16,302,133	64,524,325	80,826,458	0.108486	0.108486	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,517,784	6,066,385	7,584,169	0.424512	0.424512	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	194,683,712	344,351,186	539,034,898			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	194,683,712	344,351,186	539,034,898			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0304

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

Worksheet C
Part I
Date/Time Prepared:
5/28/2019 6:23 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
40.00	04000 SUBPROVIDER - IPF				40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
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	0.000000			60.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400 RENAL DIALYSIS	0.000000			74.00
76.00	03020 ANCILLARY	0.000000			76.00
76.01	03950 WOUND CARE	0.000000			76.01
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0304

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

Worksheet D
Part I
Date/Time Prepared:
5/28/2019 6:23 am

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Hospital Total Patient Days	Per Diem (col. 3 / col. 4)	PPS	
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	2,800,409	0	2,800,409	20,874	134.16	30.00	
31.00	INTENSIVE CARE UNIT	553,036		553,036	2,399	230.53	31.00	
40.00	SUBPROVIDER - IPF	691,614	0	691,614	6,249	110.68	40.00	
43.00	NURSERY	181,286		181,286	2,872	63.12	43.00	
200.00	Total (lines 30 through 199)	4,226,345		4,226,345	32,394		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	6,026	808,448					30.00
31.00	INTENSIVE CARE UNIT	930	214,393					31.00
40.00	SUBPROVIDER - IPF	5,165	571,662					40.00
43.00	NURSERY	0	0					43.00
200.00	Total (lines 30 through 199)	12,121	1,594,503					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0304

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

Worksheet D
Part II
Date/Time Prepared:
5/28/2019 6:23 am

Cost Center Description		Title XVIII			Hospital	PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,637,457	53,195,009	0.030782	3,335,344	102,669	50.00
51.00	05100 RECOVERY ROOM	158,545	5,946,186	0.026663	398,181	10,617	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	556,020	4,032,755	0.137876	1,434	198	52.00
53.00	05300 ANESTHESIOLOGY	35,979	14,566,766	0.002470	947,427	2,340	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	968,107	44,579,023	0.021717	2,928,998	63,609	54.00
56.00	05600 RADIOISOTOPE	295,271	5,469,712	0.053983	450,710	24,331	56.00
57.00	05700 CT SCAN	81,261	55,540,522	0.001463	4,974,454	7,278	57.00
58.00	05800 MRI	45,346	12,663,693	0.003581	785,044	2,811	58.00
59.00	05900 CARDIAC CATHETERIZATION	77,504	5,767,629	0.013438	1,438,516	19,331	59.00
60.00	06000 LABORATORY	232,381	56,944,454	0.004081	9,746,988	39,777	60.00
65.00	06500 RESPIRATORY THERAPY	43,550	10,727,725	0.004060	4,193,452	17,025	65.00
66.00	06600 PHYSICAL THERAPY	575,921	15,371,971	0.037466	861,648	32,283	66.00
67.00	06700 OCCUPATIONAL THERAPY	38,546	1,141,906	0.033756	447,590	15,109	67.00
68.00	06800 SPEECH PATHOLOGY	3,482	314,416	0.011075	134,532	1,490	68.00
69.00	06900 ELECTROCARDIOLOGY	36,975	15,889,014	0.002327	2,272,689	5,289	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	57,221	2,759,815	0.020734	65,531	1,359	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	58,731	12,353,714	0.004754	964,652	4,586	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	37,079	25,147,488	0.001474	2,798,456	4,125	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	138,700	54,123,359	0.002563	7,591,782	19,458	73.00
74.00	07400 RENAL DIALYSIS	2,472	1,211,995	0.002040	713,529	1,456	74.00
76.00	03020 ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03950 WOUND CARE	103,513	8,900	11.630674	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	66,404	658,282	0.100875	3,807	384	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	327,468	6,796,643	0.048181	16,454	793	90.00
91.00	09100 EMERGENCY	745,908	80,826,458	0.009229	5,745,050	53,021	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	455,869	7,584,169	0.060108	605,145	36,374	92.00
200.00	Total (lines 50 through 199)	6,779,710	493,621,604		51,421,413	465,713	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS Provider CCN: 14-0304
 Period: From 01/01/2018 To 12/31/2018
 Worksheet D Part III Date/Time Prepared: 5/28/2019 6:23 am

Cost Center Description			Title XVIII		Hospital	PPS		
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	20,874	0.00	6,026	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	2,399	0.00	930	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	6,249	0.00	5,165	40.00
43.00	04300	NURSERY	0	0	2,872	0.00	0	43.00
200.00		Total (lines 30 through 199)	0	0	32,394		12,121	200.00
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
			9.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0					30.00
31.00	03100	INTENSIVE CARE UNIT	0					31.00
40.00	04000	SUBPROVIDER - IPF	0					40.00
43.00	04300	NURSERY	0					43.00
200.00		Total (lines 30 through 199)	0					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0304

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

Worksheet D
Part IV
Date/Time Prepared:
5/28/2019 6:23 am

Cost Center Description		Title XVIII			Hospital		PPS	
		Non Physician Anesthetist Cost 1.00	Nursing School Post-Stepdown Adjustments 2A	Nursing School 2.00	Allied Health Post-Stepdown Adjustments 3A	Allied Health 3.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
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
76.00	03020	ANCILLARY	0	0	0	0	0	76.00
76.01	03950	WOUND CARE	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0304

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

Worksheet D
Part IV
Date/Time Prepared:
5/28/2019 6:23 am

Cost Center Description	Title XVIII			Hospital	PPS			
	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)			
	4.00	5.00	6.00	7.00	8.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	53,195,009	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	5,946,186	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	4,032,755	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	14,566,766	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	44,579,023	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	5,469,712	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	55,540,522	0.000000	57.00
58.00	05800	MRI	0	0	0	12,663,693	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	5,767,629	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	56,944,454	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,727,725	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	15,371,971	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,141,906	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	314,416	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	15,889,014	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,759,815	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	12,353,714	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	25,147,488	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	54,123,359	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,211,995	0.000000	74.00
76.00	03020	ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03950	WOUND CARE	0	0	0	8,900	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	658,282	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	6,796,643	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	80,826,458	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	7,584,169	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	493,621,604		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0304

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

Worksheet D Part IV Date/Time Prepared: 5/28/2019 6:23 am

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	3,335,344	0	9,250,774	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	398,181	0	574,347	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	1,434	0	1,648	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	947,427	0	1,978,859	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,928,998	0	4,817,608	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	450,710	0	1,302,294	0	56.00
57.00	05700	CT SCAN	0.000000	4,974,454	0	6,730,850	0	57.00
58.00	05800	MRI	0.000000	785,044	0	1,784,788	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	1,438,516	0	496,519	0	59.00
60.00	06000	LABORATORY	0.000000	9,746,988	0	3,203,769	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	4,193,452	0	367,316	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	861,648	0	68,018	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	447,590	0	29,376	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	134,532	0	2,513	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,272,689	0	2,021,063	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	65,531	0	617,602	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	964,652	0	1,829,380	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	2,798,456	0	4,359,939	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	7,591,782	0	10,001,039	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	713,529	0	0	0	74.00
76.00	03020	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03950	WOUND CARE	0.000000	0	0	1,403	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	3,807	0	287,389	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	16,454	0	1,069,126	0	90.00
91.00	09100	EMERGENCY	0.000000	5,745,050	0	5,584,139	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	605,145	0	1,252,096	0	92.00
200.00		Total (lines 50 through 199)		51,421,413	0	57,631,855	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0304

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

Worksheet D
Part V
Date/Time Prepared:
5/28/2019 6:23 am

Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Hospital		PPS	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	0.246023	9,250,774	0	0	2,275,903	50.00	
51.00	05100 RECOVERY ROOM	0.230357	574,347	0	0	132,305	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.927726	1,648	0	0	1,529	52.00	
53.00	05300 ANESTHESIOLOGY	0.022484	1,978,859	0	0	44,493	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.135637	4,817,608	0	0	653,446	54.00	
56.00	05600 RADIOISOTOPE	0.180061	1,302,294	0	0	234,492	56.00	
57.00	05700 CT SCAN	0.028365	6,730,850	0	0	190,921	57.00	
58.00	05800 MRI	0.049092	1,784,788	0	0	87,619	58.00	
59.00	05900 CARDIAC CATHETERIZATION	0.195651	496,519	0	0	97,144	59.00	
60.00	06000 LABORATORY	0.077035	3,203,769	0	0	246,802	60.00	
65.00	06500 RESPIRATORY THERAPY	0.146816	367,316	0	0	53,928	65.00	
66.00	06600 PHYSICAL THERAPY	0.464363	68,018	0	0	31,585	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0.148983	29,376	0	0	4,377	67.00	
68.00	06800 SPEECH PATHOLOGY	0.072226	2,513	0	0	182	68.00	
69.00	06900 ELECTROCARDIOLOGY	0.068949	2,021,063	0	0	139,350	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY	0.167580	617,602	0	0	103,498	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.641048	1,829,380	0	0	1,172,720	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.285972	4,359,939	0	0	1,246,820	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.203896	10,001,039	0	52,991	2,039,172	73.00	
74.00	07400 RENAL DIALYSIS	0.418324	0	0	0	0	74.00	
76.00	03020 ANCILLARY	0.000000	0	0	0	0	76.00	
76.01	03950 WOUND CARE	26.883371	1,403	0	0	37,717	76.01	
76.97	07697 CARDIAC REHABILITATION	0.540332	287,389	0	0	155,285	76.97	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000 CLINIC	0.378443	1,069,126	0	0	404,603	90.00	
91.00	09100 EMERGENCY	0.108486	5,584,139	0	0	605,801	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.424512	1,252,096	0	0	531,530	92.00	
200.00	Subtotal (see instructions)		57,631,855	0	52,991	10,491,222	200.00	
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00	Net Charges (line 200 - line 201)		57,631,855	0	52,991	10,491,222	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0304

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

Worksheet D
Part V
Date/Time Prepared:
5/28/2019 6:23 am

Cost Center Description	Costs		Title XVIII	Hospital	PPS
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
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
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	10,805	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03020	ANCILLARY	0	0	76.00
76.01	03950	WOUND CARE	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	10,805	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	10,805	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0304		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part II Date/Time Prepared: 5/28/2019 6:23 am	
		Component CCN: 14-S304		Title XVIII		Subprovider - IPF PPS	
Cost Center Description	Capital Related Cost (from wkst. B, Part II, col. 26)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,637,457	53,195,009	0.030782	0	0	50.00
51.00	05100 RECOVERY ROOM	158,545	5,946,186	0.026663	6,732	179	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	556,020	4,032,755	0.137876	0	0	52.00
53.00	05300 ANESTHESIOLOGY	35,979	14,566,766	0.002470	12,360	31	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	968,107	44,579,023	0.021717	139,141	3,022	54.00
56.00	05600 RADIOISOTOPE	295,271	5,469,712	0.053983	0	0	56.00
57.00	05700 CT SCAN	81,261	55,540,522	0.001463	236,000	345	57.00
58.00	05800 MRI	45,346	12,663,693	0.003581	14,000	50	58.00
59.00	05900 CARDIAC CATHETERIZATION	77,504	5,767,629	0.013438	0	0	59.00
60.00	06000 LABORATORY	232,381	56,944,454	0.004081	846,755	3,456	60.00
65.00	06500 RESPIRATORY THERAPY	43,550	10,727,725	0.004060	229,876	933	65.00
66.00	06600 PHYSICAL THERAPY	575,921	15,371,971	0.037466	280,157	10,496	66.00
67.00	06700 OCCUPATIONAL THERAPY	38,546	1,141,906	0.033756	84,413	2,849	67.00
68.00	06800 SPEECH PATHOLOGY	3,482	314,416	0.011075	22,672	251	68.00
69.00	06900 ELECTROCARDIOLOGY	36,975	15,889,014	0.002327	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	57,221	2,759,815	0.020734	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	58,731	12,353,714	0.004754	362	2	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	37,079	25,147,488	0.001474	34	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	138,700	54,123,359	0.002563	1,164,865	2,986	73.00
74.00	07400 RENAL DIALYSIS	2,472	1,211,995	0.002040	0	0	74.00
76.00	03020 ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03950 WOUND CARE	103,513	8,900	11.630674	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	66,404	658,282	0.100875	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	327,468	6,796,643	0.048181	0	0	90.00
91.00	09100 EMERGENCY	745,908	80,826,458	0.009229	432,352	3,990	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	7,584,169	0.000000	26,217	0	92.00
200.00	Total (lines 50 through 199)	6,323,841	493,621,604		3,495,936	28,590	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS
 Provider CCN: 14-0304
 Component CCN: 14-S304
 Period: From 01/01/2018 To 12/31/2018
 Worksheet D Part IV
 Date/Time Prepared: 5/28/2019 6:23 am

Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
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
76.00	03020	ANCILLARY	0	0	0	0	0	76.00
76.01	03950	WOUND CARE	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0304 Component CCN: 14-S304	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/28/2019 6:23 am
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Cost Center Description		All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
		4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	53,195,009	0.000000	50.00
51.00	05100 RECOVERY ROOM	0	0	0	5,946,186	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	4,032,755	0.000000	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	14,566,766	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	44,579,023	0.000000	54.00
56.00	05600 RADIOISOTOPE	0	0	0	5,469,712	0.000000	56.00
57.00	05700 CT SCAN	0	0	0	55,540,522	0.000000	57.00
58.00	05800 MRI	0	0	0	12,663,693	0.000000	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	5,767,629	0.000000	59.00
60.00	06000 LABORATORY	0	0	0	56,944,454	0.000000	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	10,727,725	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	15,371,971	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	1,141,906	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	314,416	0.000000	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	15,889,014	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	2,759,815	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	12,353,714	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	25,147,488	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	54,123,359	0.000000	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	1,211,995	0.000000	74.00
76.00	03020 ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03950 WOUND CARE	0	0	0	8,900	0.000000	76.01
76.97	07697 CARDIAC REHABILITATION	0	0	0	658,282	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	6,796,643	0.000000	90.00
91.00	09100 EMERGENCY	0	0	0	80,826,458	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	7,584,169	0.000000	92.00
200.00	Total (lines 50 through 199)	0	0	0	493,621,604		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS
 Provider CCN: 14-0304
 Component CCN: 14-S304
 Period: From 01/01/2018 To 12/31/2018
 Worksheet D Part IV Date/Time Prepared: 5/28/2019 6:23 am

Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
		9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.000000	0	0	0	0 50.00
51.00	05100 RECOVERY ROOM	0.000000	6,732	0	0	0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0.000000	12,360	0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	139,141	0	490	0 54.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0 56.00
57.00	05700 CT SCAN	0.000000	236,000	0	2,400	0 57.00
58.00	05800 MRI	0.000000	14,000	0	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0 59.00
60.00	06000 LABORATORY	0.000000	846,755	0	0	0 60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	229,876	0	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.000000	280,157	0	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	84,413	0	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	22,672	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	690	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	362	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	34	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	1,164,865	0	5,838	0 73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0 74.00
76.00	03020 ANCILLARY	0.000000	0	0	0	0 76.00
76.01	03950 WOUND CARE	0.000000	0	0	0	0 76.01
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0 76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0.000000	0	0	0	0 90.00
91.00	09100 EMERGENCY	0.000000	432,352	0	1,836	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	26,217	0	0	0 92.00
200.00	Total (lines 50 through 199)		3,495,936	0	11,254	0 200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0304	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V
	Component CCN: 14-S304		Date/Time Prepared: 5/28/2019 6:23 am
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Cost to Charge Ratio From worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.246023	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.230357	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.927726	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.022484	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.135637	490	0	0	66 54.00
56.00	05600 RADIOISOTOPE	0.180061	0	0	0	56.00
57.00	05700 CT SCAN	0.028365	2,400	0	0	68 57.00
58.00	05800 MRI	0.049092	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.195651	0	0	0	59.00
60.00	06000 LABORATORY	0.077035	0	0	1,525	60.00
65.00	06500 RESPIRATORY THERAPY	0.146816	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.464363	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.148983	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.072226	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.068949	690	0	0	48 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.167580	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.641048	0	0	19	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.285972	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.203896	5,838	0	995	1,190 73.00
74.00	07400 RENAL DIALYSIS	0.418324	0	0	0	74.00
76.00	03020 ANCILLARY	0.000000	0	0	0	76.00
76.01	03950 WOUND CARE	26.883371	0	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0.540332	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0.378443	0	0	0	90.00
91.00	09100 EMERGENCY	0.108486	1,836	0	7,956	199 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.424512	0	0	279	0 92.00
200.00	Subtotal (see instructions)		11,254	0	10,774	1,571 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0 201.00
202.00	Net Charges (line 200 - line 201)		11,254	0	10,774	1,571 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0304

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

Worksheet D
Part V
Date/Time Prepared:
5/28/2019 6:23 am

Component CCN: 14-S304

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description	Costs				
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
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
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	117	60.00
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	12	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	203	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03020	ANCILLARY	0	0	76.00
76.01	03950	WOUND CARE	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	863	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	118	92.00
200.00		Subtotal (see instructions)	0	1,313	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	1,313	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0304 Component CCN: 14-S304		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part II Date/Time Prepared: 5/28/2019 6:23 am	
Title XIX				Subprovider - IPF		TEFRA	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,637,457	53,195,009	0.030782	0	0	50.00
51.00	05100 RECOVERY ROOM	158,545	5,946,186	0.026663	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	556,020	4,032,755	0.137876	0	0	52.00
53.00	05300 ANESTHESIOLOGY	35,979	14,566,766	0.002470	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	968,107	44,579,023	0.021717	0	0	54.00
56.00	05600 RADIOISOTOPE	295,271	5,469,712	0.053983	0	0	56.00
57.00	05700 CT SCAN	81,261	55,540,522	0.001463	0	0	57.00
58.00	05800 MRI	45,346	12,663,693	0.003581	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	77,504	5,767,629	0.013438	0	0	59.00
60.00	06000 LABORATORY	232,381	56,944,454	0.004081	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	43,550	10,727,725	0.004060	0	0	65.00
66.00	06600 PHYSICAL THERAPY	575,921	15,371,971	0.037466	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	38,546	1,141,906	0.033756	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	3,482	314,416	0.011075	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	36,975	15,889,014	0.002327	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	57,221	2,759,815	0.020734	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	58,731	12,353,714	0.004754	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	37,079	25,147,488	0.001474	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	138,700	54,123,359	0.002563	0	0	73.00
74.00	07400 RENAL DIALYSIS	2,472	1,211,995	0.002040	0	0	74.00
76.00	03020 ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03950 WOUND CARE	103,513	8,900	11.630674	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	66,404	658,282	0.100875	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	327,468	6,796,643	0.048181	0	0	90.00
91.00	09100 EMERGENCY	745,908	80,826,458	0.009229	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	7,584,169	0.000000	0	0	92.00
200.00	Total (lines 50 through 199)	6,323,841	493,621,604		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0304
Component CCN: 14-S304

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

Worksheet D
Part IV
Date/Time Prepared:
5/28/2019 6:23 am

		Title XIX		Subprovider - IPF		TEFRA		
Cost Center Description		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
		1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
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
76.00	03020	ANCILLARY	0	0	0	0	0	76.00
76.01	03950	WOUND CARE	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS
 Provider CCN: 14-0304
 Component CCN: 14-S304
 Period: From 01/01/2018 To 12/31/2018
 Worksheet D Part IV
 Date/Time Prepared: 5/28/2019 6:23 am

Cost Center Description		All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
		4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	53,195,009	0.000000	50.00
51.00	05100 RECOVERY ROOM	0	0	0	5,946,186	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	4,032,755	0.000000	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	14,566,766	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	44,579,023	0.000000	54.00
56.00	05600 RADIOISOTOPE	0	0	0	5,469,712	0.000000	56.00
57.00	05700 CT SCAN	0	0	0	55,540,522	0.000000	57.00
58.00	05800 MRI	0	0	0	12,663,693	0.000000	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	5,767,629	0.000000	59.00
60.00	06000 LABORATORY	0	0	0	56,944,454	0.000000	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	10,727,725	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	15,371,971	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	1,141,906	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	314,416	0.000000	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	15,889,014	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	2,759,815	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	12,353,714	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	25,147,488	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	54,123,359	0.000000	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	1,211,995	0.000000	74.00
76.00	03020 ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03950 WOUND CARE	0	0	0	8,900	0.000000	76.01
76.97	07697 CARDIAC REHABILITATION	0	0	0	658,282	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	6,796,643	0.000000	90.00
91.00	09100 EMERGENCY	0	0	0	80,826,458	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	7,584,169	0.000000	92.00
200.00	Total (lines 50 through 199)	0	0	0	493,621,604		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS
 Provider CCN: 14-0304
 Component CCN: 14-S304
 Period: From 01/01/2018 To 12/31/2018
 Worksheet D Part IV Date/Time Prepared: 5/28/2019 6:23 am

Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MRI	0.000000	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03020 ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03950 WOUND CARE	0.000000	0	0	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00	Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0304	Period: From 01/01/2018 To 12/31/2018	worksheet D-1
	Title XVIII	Hospital	Date/Time Prepared: 5/28/2019 6:23 am

Cost Center Description		PPS	
		1.00	
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	20,874	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	20,874	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)	17,476	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)	6,026	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	19,777,895	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	19,777,895	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	19,777,895	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY			
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	947.49	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	5,709,575	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)	5,709,575	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0304

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

Worksheet D-1

Date/Time Prepared:
5/28/2019 6:23 am

Cost Center Description	Title XVIII			Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	5,634,834	2,399	2,348.83	930	2,184,412	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						
					1.00	
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					8,038,693	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					15,932,680	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					1,022,841	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					465,713	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,488,554	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					14,444,126	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)					3,398	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					947.49	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					3,219,571	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0304

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

worksheet D-1
Date/Time Prepared:
5/28/2019 6:23 am

Cost Center Description	Title XVIII			Hospital	PPS	
	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	2,800,409	19,777,895	0.141593	3,219,571	455,869	90.00
91.00 Nursing School cost	0	19,777,895	0.000000	3,219,571	0	91.00
92.00 Allied health cost	0	19,777,895	0.000000	3,219,571	0	92.00
93.00 All other Medical Education	0	19,777,895	0.000000	3,219,571	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0304	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1
	Component CCN: 14-S304		Date/Time Prepared: 5/28/2019 6:23 am
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description		1.00	
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,249	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,249	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)	6,249	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)	5,165	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,720,279	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)	5,720,279	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,720,279	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY			
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	915.39	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,727,989	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)	4,727,989	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0304		Period: From 01/01/2018 To 12/31/2018		worksheet D-1	
		Component CCN: 14-S304		Date/Time Prepared: 5/28/2019 6:23 am			
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					567,157	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,295,146	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)					571,662	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					28,590	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					600,252	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					4,694,894	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0304
Component CCN: 14-S304

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

Worksheet D-1
Date/Time Prepared:
5/28/2019 6:23 am

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description	Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	691,614	5,720,279	0.120906	0	0	90.00
91.00 Nursing School cost	0	5,720,279	0.000000	0	0	91.00
92.00 Allied health cost	0	5,720,279	0.000000	0	0	92.00
93.00 All other Medical Education	0	5,720,279	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0304
Component CCN: 14-S304

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

worksheet D-1
Date/Time Prepared:
5/28/2019 6:23 am

Title XIX

Subprovider -
IPF

TEFRA

Cost Center Description

1.00

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,249	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,249	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)	6,249	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)	47	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	2,872	15.00
16.00	Nursery days (title V or XIX only)	466	16.00

SWING BED ADJUSTMENT

17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,720,279	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)	5,720,279	27.00

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,720,279	37.00

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS

38.00	Adjusted general inpatient routine service cost per diem (see instructions)	915.39	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	43,023	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)	43,023	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0304		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1	
		Component CCN: 14-S304		Date/Time Prepared: 5/28/2019 6:23 am			
		Title XIX		Subprovider - IPF		TEFRA	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title v & XIX only)	1.00	2.00	3.00	4.00	5.00	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					0	48.00	
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					43,023	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)					0	50.00	
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00	
52.00 Total Program excludable cost (sum of lines 50 and 51)					0	52.00	
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					43,023	53.00	
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					2	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)					-43,023	57.00	
58.00 Bonus payment (see instructions)					0	58.00	
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00	
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00	
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00	
62.00 Relief payment (see instructions)					0	62.00	
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00	
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00	
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00	
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00	
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00	
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00	
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00	
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00	
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00	
72.00 Program routine service cost (line 9 x line 71)						72.00	
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00	
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00	
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00	
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00	
77.00 Program capital-related costs (line 9 x line 76)						77.00	
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00	
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00	
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00	
81.00 Inpatient routine service cost per diem limitation						81.00	
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00	
83.00 Reasonable inpatient routine service costs (see instructions)						83.00	
84.00 Program inpatient ancillary services (see instructions)						84.00	
85.00 Utilization review - physician compensation (see instructions)						85.00	
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00	
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0	87.00	
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00	
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0304
Component CCN: 14-S304

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

Worksheet D-1
Date/Time Prepared:
5/28/2019 6:23 am

Title XIX

Subprovider -
IPF

TEFRA

Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	0	5,720,279	0.000000	0	0	90.00
91.00 Nursing School cost	0	5,720,279	0.000000	0	0	91.00
92.00 Allied health cost	0	5,720,279	0.000000	0	0	92.00
93.00 All other Medical Education	0	5,720,279	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 14-0304	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3
			Date/Time Prepared: 5/28/2019 6:23 am

Cost Center Description	Title XVIII	Hospital		PPS
		Ratio of Cost To Charges	Inpatient Program Charges	
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		6,846,047	30.00
31.00	03100 INTENSIVE CARE UNIT		2,018,843	31.00
40.00	04000 SUBPROVIDER - IPF		0	40.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.246023	3,335,344	820,571 50.00
51.00	05100 RECOVERY ROOM	0.230357	398,181	91,724 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.927726	1,434	1,330 52.00
53.00	05300 ANESTHESIOLOGY	0.022484	947,427	21,302 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.135637	2,928,998	397,281 54.00
56.00	05600 RADIOISOTOPE	0.180061	450,710	81,155 56.00
57.00	05700 CT SCAN	0.028365	4,974,454	141,100 57.00
58.00	05800 MRI	0.049092	785,044	38,539 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.195651	1,438,516	281,447 59.00
60.00	06000 LABORATORY	0.077035	9,746,988	750,859 60.00
65.00	06500 RESPIRATORY THERAPY	0.146816	4,193,452	615,666 65.00
66.00	06600 PHYSICAL THERAPY	0.464363	861,648	400,117 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.148983	447,590	66,683 67.00
68.00	06800 SPEECH PATHOLOGY	0.072226	134,532	9,717 68.00
69.00	06900 ELECTROCARDIOLOGY	0.068949	2,272,689	156,700 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.167580	65,531	10,982 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.641048	964,652	618,388 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.285972	2,798,456	800,280 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.203896	7,591,782	1,547,934 73.00
74.00	07400 RENAL DIALYSIS	0.418324	713,529	298,486 74.00
76.00	03020 ANCILLARY	0.000000	0	0 76.00
76.01	03950 WOUND CARE	26.883371	0	0 76.01
76.97	07697 CARDIAC REHABILITATION	0.540332	3,807	2,057 76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.378443	16,454	6,227 90.00
91.00	09100 EMERGENCY	0.108486	5,745,050	623,257 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.424512	605,145	256,891 92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		51,421,413	8,038,693 200.00
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)		51,421,413	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0304
Component CCN: 14-S304

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

worksheet D-3
Date/Time Prepared:
5/28/2019 6:23 am

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		8,078,950		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.246023	0	0	50.00
51.00	05100 RECOVERY ROOM	0.230357	6,732	1,551	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.927726	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.022484	12,360	278	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.135637	139,141	18,873	54.00
56.00	05600 RADIOISOTOPE	0.180061	0	0	56.00
57.00	05700 CT SCAN	0.028365	236,000	6,694	57.00
58.00	05800 MRI	0.049092	14,000	687	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.195651	0	0	59.00
60.00	06000 LABORATORY	0.077035	846,755	65,230	60.00
65.00	06500 RESPIRATORY THERAPY	0.146816	229,876	33,749	65.00
66.00	06600 PHYSICAL THERAPY	0.464363	280,157	130,095	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.148983	84,413	12,576	67.00
68.00	06800 SPEECH PATHOLOGY	0.072226	22,672	1,638	68.00
69.00	06900 ELECTROCARDIOLOGY	0.068949	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.167580	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.641048	362	232	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.285972	34	10	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.203896	1,164,865	237,511	73.00
74.00	07400 RENAL DIALYSIS	0.418324	0	0	74.00
76.00	03020 ANCILLARY	0.000000	0	0	76.00
76.01	03950 WOUND CARE	26.883371	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0.540332	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.378443	0	0	90.00
91.00	09100 EMERGENCY	0.108486	432,352	46,904	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.424512	26,217	11,129	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		3,495,936	567,157	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)		3,495,936		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0304

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

Worksheet E
Part A
Date/Time Prepared:
5/28/2019 6:23 am

		Title XVIII	Hospital	PPS	
				1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			10,064,279	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			3,603,732	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)			80,971	2.00
2.01	Outlier reconciliation amount			0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)			0	2.02
3.00	Managed Care Simulated Payments			0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			100.30	4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)			0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).			0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)			0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)			0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.			0.00	11.00
12.00	Current year allowable FTE (see instructions)			0.00	12.00
13.00	Total allowable FTE count for the prior year.			0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.			0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.			0.00	15.00
16.00	Adjustment for residents in initial years of the program			0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure			0.00	17.00
18.00	Adjusted rolling average FTE count			0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	21.00
22.00	IME payment adjustment (see instructions)			0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).			0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)			0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)			0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)			0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)			0	28.01
29.00	Total IME payment (sum of lines 22 and 28)			0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			4.24	30.00
31.00	Percentage of Medicaid patient days (see instructions)			26.54	31.00
32.00	Sum of lines 30 and 31			30.78	32.00
33.00	Allowable disproportionate share percentage (see instructions)			14.61	33.00
34.00	Disproportionate share adjustment (see instructions)			499,224	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0304	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/28/2019 6:23 am	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		6,766,695,164	8,272,872,447	35.00
35.01	Factor 3 (see instructions)		0.000166582	0.000132305	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		1,127,212	1,094,538	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		843,093	275,884	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,118,977		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		15,367,183		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)		15,367,183		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,196,857		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)		16,564,040		59.00
60.00	Primary payer payments		37,170		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		16,526,870		61.00
62.00	Deductibles billed to program beneficiaries		1,468,304		62.00
63.00	Coinsurance billed to program beneficiaries		77,385		63.00
64.00	Allowable bad debts (see instructions)		272,404		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		177,063		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		158,818		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		15,158,244		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)		30,157		70.93
70.94	HRR adjustment amount (see instructions)		-77,833		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0304	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/28/2019 6:23 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	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	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)			15,110,568	71.00
71.01	Sequestration adjustment (see instructions)			302,211	71.01
71.02	Demonstration payment adjustment amount after sequestration			0	71.02
72.00	Interim payments			14,812,352	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)			-3,995	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			540,266	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)			0	90.00
91.00	Capital outlier from wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
				Prior to 10/1 1.00	On/After 10/1 2.00
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

		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	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	10,064,279	0	10,064,279		10,064,279		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,603,732	0		3,603,732	3,603,732		1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0		1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0		1.04
2.00	Outlier payments for discharges (see instructions)	2.00	80,971	0	57,241	23,730	80,971		2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0		2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0		3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0		4.00
Indirect Medical Education Adjustment									
5.00	Amount from worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000			5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0		6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0		6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA									
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000			7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0		8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0		8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0		9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0		9.01
Disproportionate Share Adjustment									
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1461	0.1461	0.1461	0.1461			10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	499,224	0	367,598	131,626	499,224		11.00
11.01	Uncompensated care payments	36.00	1,118,977	0	843,093	275,884	1,118,977		11.01
Additional payment for high percentage of ESRD beneficiary discharges									
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0		12.00
13.00	Subtotal (see instructions)	47.00	15,367,183	0	11,332,211	4,034,972	15,367,183		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	15,367,183	0	11,332,211	4,034,972	15,367,183		15.00
16.00	Payment for inpatient program capital (from wkst. L, Pt. I, if applicable)	50.00	1,196,857	0	881,828	315,029	1,196,857		16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0		17.00
17.01	Net organ aquisition cost								17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0		17.02

		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	12,214,039	4,350,001	16,564,040	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,112,910	0	819,712	293,198	1,112,910	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	12,387	0	9,409	2,978	12,387	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	0.0643	0.0643	0.0643	0.0643		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	71,560	0	52,707	18,853	71,560	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,196,857	0	881,828	315,029	1,196,857	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

		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	10,064,279	10,064,279		10,064,279	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,603,732		3,603,732	3,603,732	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	-1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	80,971	57,241	23,730	80,971	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1461	0.1461	0.1461		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	499,224	367,598	131,626	499,224	11.00
11.01	Uncompensated care payments	36.00	1,118,977	843,093	275,884	1,118,977	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	15,367,183	11,332,211	4,034,972	15,367,183	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	15,367,183	11,332,211	4,034,972	15,367,183	15.00
16.00	Payment for inpatient program capital (from wkst. L, Pt. 1, if applicable)	50.00	1,196,857	881,828	315,029	1,196,857	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			12,214,039	4,350,001	16,564,040	19.00

		Title XVIII				Hospital	PPS
		wkst. L, line	(Amt. from wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,112,910	819,712	293,198	1,112,910	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	12,387	9,409	2,978	12,387	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	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	0.0643	0.0643	0.0643	0.0643	24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	71,560	52,707	18,853	71,560	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,196,857	881,828	315,029	1,196,857	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	30,157	30,225	-68	30,157	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	-77,833	-58,373	-19,460	-77,833	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: 14-0304	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/28/2019 6:23 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		10,805	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		10,491,222	2.00
3.00	OPPS payments		10,590,949	3.00
4.00	Outlier payment (see instructions)		23,468	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)		10,805	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		52,991	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)		52,991	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis 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)		52,991	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		42,186	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)		10,805	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		10,614,417	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,954,060	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		8,671,162	27.00
28.00	Direct graduate medical education payments (from wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		8,671,162	30.00
31.00	Primary payer payments		2,926	31.00
32.00	Subtotal (line 30 minus line 31)		8,668,236	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		323,994	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		210,596	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		209,261	36.00
37.00	Subtotal (see instructions)		8,878,832	37.00
38.00	MSP-LCC reconciliation amount from PS&R		412	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		8,878,420	40.00
40.01	Sequestration adjustment (see instructions)		177,568	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		8,632,780	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		68,072	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0304	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/28/2019 6:23 am
		Component CCN: 14-S304	Title XVIII	Subprovider - IPF
				PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		1,313	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		1,571	2.00
3.00	OPPS payments		2,662	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)		1,313	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		10,774	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)		10,774	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		10,774	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		9,461	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)		1,313	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)		2,662	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		395	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)		3,580	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)		3,580	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		3,580	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		3,580	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	39.50
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)		3,580	40.00
40.01	Sequestration adjustment (see instructions)		72	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		3,938	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-430	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0304

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

worksheet E-1
Part I
Date/Time Prepared:
5/28/2019 6:23 am

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		14,800,706		8,692,777	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	12/18/2018	11,646		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0	12/18/2018	59,997	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)		11,646		-59,997	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)		14,812,352		8,632,780	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		68,072	6.01
6.02	SETTLEMENT TO PROGRAM		3,995		0	6.02
7.00	Total Medicare program liability (see instructions)		14,808,357		8,700,852	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0304
Component CCN: 14-S304

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

Worksheet E-1
Part I
Date/Time Prepared:
5/28/2019 6:23 am

Title XVIII

Subprovider -
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		5,409,310		3,938	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or wkst. E-3, line and column as appropriate)		5,409,310		3,938	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		3		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		430	6.02
7.00	Total Medicare program liability (see instructions)		5,409,313		3,508	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: 14-0304

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

Worksheet E-1
Part II
Date/Time Prepared:
5/28/2019 6:23 am

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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-0304	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part II Date/Time Prepared: 5/28/2019 6:23 am
		Component CCN:14-S304	Title XVIII	Subprovider - IPF
				PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		5,179,039	1.00
2.00	Net IPF PPS Outlier Payments		574,686	2.00
3.00	Net IPF PPS ECT Payments		2,061	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		17.120548	9.00
10.00	Teaching Adjustment Factor {(1 + (line 8/line 9)) raised to the power of .5150 -1}.		0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		5,755,786	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		0	14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		5,755,786	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		5,755,786	18.00
19.00	Deductibles		212,964	19.00
20.00	Subtotal (line 18 minus line 19)		5,542,822	20.00
21.00	Coinsurance		23,115	21.00
22.00	Subtotal (line 20 minus line 21)		5,519,707	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	25.00
26.00	Subtotal (sum of lines 22 and 24)		5,519,707	26.00
27.00	Direct graduate medical education payments (from wkst. E-4, line 49)		0	27.00
28.00	Other pass through costs (see instructions)		0	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	30.50
30.99	Demonstration payment adjustment amount before sequestration		0	30.99
31.00	Total amount payable to the provider (see instructions)		5,519,707	31.00
31.01	Sequestration adjustment (see instructions)		110,394	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	31.02
32.00	Interim payments		5,409,310	32.00
33.00	Tentative settlement (for contractor use only)		0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)		3	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from worksheet E-3, Part II, line 2		574,686	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

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

Provider CCN: 14-0304

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

Worksheet G
Date/Time Prepared:
5/28/2019 6:23 am

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00	Cash on hand in banks	-2,844,095	0	0	0 1.00
2.00	Temporary investments	7,831	0	0	0 2.00
3.00	Notes receivable	0	0	0	0 3.00
4.00	Accounts receivable	76,685,477	0	0	0 4.00
5.00	Other receivable	0	0	0	0 5.00
6.00	Allowances for uncollectible notes and accounts receivable	-53,313,182	0	0	0 6.00
7.00	Inventory	2,438,463	0	0	0 7.00
8.00	Prepaid expenses	589,105	0	0	0 8.00
9.00	Other current assets	0	0	0	0 9.00
10.00	Due from other funds	0	0	0	0 10.00
11.00	Total current assets (sum of lines 1-10)	23,563,599	0	0	0 11.00
FIXED ASSETS					
12.00	Land	3,750,000	0	0	0 12.00
13.00	Land improvements	312,035	0	0	0 13.00
14.00	Accumulated depreciation	-133,840	0	0	0 14.00
15.00	Buildings	110,312,781	0	0	0 15.00
16.00	Accumulated depreciation	-40,115,059	0	0	0 16.00
17.00	Leasehold improvements	1,710,040	0	0	0 17.00
18.00	Accumulated depreciation	-1,220,597	0	0	0 18.00
19.00	Fixed equipment	23,136,181	0	0	0 19.00
20.00	Accumulated depreciation	-17,161,669	0	0	0 20.00
21.00	Automobiles and trucks	0	0	0	0 21.00
22.00	Accumulated depreciation	0	0	0	0 22.00
23.00	Major movable equipment	39,516,196	0	0	0 23.00
24.00	Accumulated depreciation	-35,415,858	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)	84,690,210	0	0	0 30.00
OTHER ASSETS					
31.00	Investments	1,814,717	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	3,390,634	0	0	0 34.00
35.00	Total other assets (sum of lines 31-34)	5,205,351	0	0	0 35.00
36.00	Total assets (sum of lines 11, 30, and 35)	113,459,160	0	0	0 36.00
CURRENT LIABILITIES					
37.00	Accounts payable	6,843,690	0	0	0 37.00
38.00	Salaries, wages, and fees payable	1,134,542	0	0	0 38.00
39.00	Payroll taxes payable	2,250,604	0	0	0 39.00
40.00	Notes and loans payable (short term)	0	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	23,062,624	0	0	0 44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	33,291,460	0	0	0 45.00
LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0 46.00
47.00	Notes payable	71,101,657	0	0	0 47.00
48.00	Unsecured loans	0	0	0	0 48.00
49.00	Other long term liabilities	143,469	0	0	0 49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	71,245,126	0	0	0 50.00
51.00	Total liabilities (sum of lines 45 and 50)	104,536,586	0	0	0 51.00
CAPITAL ACCOUNTS					
52.00	General fund balance	8,922,574	0	0	0 52.00
53.00	Specific purpose fund	0	0	0	0 53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0 54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0 55.00
56.00	Governing body created - endowment fund balance	0	0	0	0 56.00
57.00	Plant fund balance - invested in plant	0	0	0	0 57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0 58.00
59.00	Total fund balances (sum of lines 52 thru 58)	8,922,574	0	0	0 59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	113,459,160	0	0	0 60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0304

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

Worksheet G-1
Date/Time Prepared:
5/28/2019 6:23 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		5,431,227			0	1.00
2.00	Net income (loss) (from wkst. G-3, line 29)		4,436,496				2.00
3.00	Total (sum of line 1 and line 2)		9,867,723			0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0			0	10.00
11.00	Subtotal (line 3 plus line 10)		9,867,723			0	11.00
12.00	UNRESTRICTED ASSETS	945,151					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)		945,151			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		8,922,572			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	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	UNRESTRICTED ASSETS		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0304

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/28/2019 6:23 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	27,689,865		27,689,865	1.00
2.00	SUBPROVIDER - IPF	9,780,521		9,780,521	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	37,470,386		37,470,386	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,558,292		5,558,292	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	5,558,292		5,558,292	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	43,028,678		43,028,678	17.00
18.00	Ancillary services	132,986,921	282,532,458	415,519,379	18.00
19.00	Outpatient services	16,316,648	64,524,325	80,840,973	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHARMACY	0	2,454,811	2,454,811	27.00
27.01	PHYSICIAN REVENUE	0	599,296	599,296	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	192,332,247	350,110,890	542,443,137	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		133,226,034		29.00
30.00	BAD DEBT	12,023,559			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		12,023,559		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to wkst. G-3, line 4)		145,249,593		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0304

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

Worksheet G-3

Date/Time Prepared:
5/28/2019 6:23 am

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	542,443,137	1.00
2.00	Less contractual allowances and discounts on patients' accounts	394,374,887	2.00
3.00	Net patient revenues (line 1 minus line 2)	148,068,250	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	145,249,593	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,818,657	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	EHR REVENUE; OTHER OPER; NON OPER	1,617,839	24.00
25.00	Total other income (sum of lines 6-24)	1,617,839	25.00
26.00	Total (line 5 plus line 25)	4,436,496	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)	4,436,496	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0304	Period: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III Date/Time Prepared: 5/28/2019 6:23 am
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,112,910	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		12,387	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)		54.90	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)		4.24	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		26.54	8.00
9.00	Sum of lines 7 and 8		30.78	9.00
10.00	Allowable disproportionate share percentage (see instructions)		6.43	10.00
11.00	Disproportionate share adjustment (see instructions)		71,560	11.00
12.00	Total prospective capital payments (see instructions)		1,196,857	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00