

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: 14-0307	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/29/2019 10:23 am
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PART I - COST REPORT STATUS

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

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

Date: 5/29/2019 Time: 10:23 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 MEMORIAL HOSPITAL EAST (14-0307) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

 Title

 Date

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	170,218	54,723	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0	0	0		0	6.00
200.00 Total	0	170,218	54,723	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0307	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 10:23 am
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1.00 Hospital and Hospital Health Care Complex Address:	2.00 PO Box:	3.00 Zip Code: 62269	4.00 County: ST. CLAIR	1.00 Street: 1404 CROSS STREET	2.00 State: IL
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Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
					V	XVIII	XIX

Hospital and Hospital-Based Component Identification:									
3.00 Hospital	MEMORIAL HOSPITAL EAST	140307	41180	1	05/16/2016	N	P	O	3.00
4.00 Subprovider - IPF									4.00
5.00 Subprovider - IRF									5.00
6.00 Subprovider - (Other)									6.00
7.00 Swing Beds - SNF									7.00
8.00 Swing Beds - NF									8.00
9.00 Hospital-Based SNF									9.00
10.00 Hospital-Based NF									10.00
11.00 Hospital-Based OLTC									11.00
12.00 Hospital-Based HHA									12.00
13.00 Separately Certified ASC									13.00
14.00 Hospital-Based Hospice									14.00
15.00 Hospital-Based Health Clinic - RHC									15.00
16.00 Hospital-Based Health Clinic - FQHC									16.00
17.00 Hospital-Based (CMHC) I									17.00
18.00 Renal Dialysis									18.00
19.00 Other									19.00

		From:	To:	
20.00 Cost Reporting Period (mm/dd/yyyy)		1.00 01/01/2018	2.00 12/31/2018	20.00
21.00 Type of Control (see instructions)		2		21.00

		1.00	2.00	3.00
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Inpatient PPS Information					
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	N	22.03
23.00	Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.		3	N	23.00

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
	1.00	2.00	3.00	4.00	5.00	6.00		
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	766	1,180	19		5	2,480	11	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0307		Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 10:23 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	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 OPSS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00	
						V	XVII	XIX	
						1.00	2.00	3.00	
<u>Prospective Payment System (PPS)-Capital</u>									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					Y	Y	Y	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
<u>Teaching Hospitals</u>									
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.								58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criteria Code			
				1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)					N		60.00	

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

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

5/29/2019 10:23 am

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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	N	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	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.				109.00
				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.		N	110.00	

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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:	1,160,780	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.	Y		5.00		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		269026		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0307	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 10:23 am			
1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: BJC HEALTHCARE	Contractor's Name: WPS		Contractor's Number: 05301			
142.00	Street: 4901 FOREST PARK PARKWAY	PO Box:					
143.00	City: ST. LOUIS	State: MO	Zip Code: 63108				
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?				Y	144.00	
				1.00	2.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			Y	145.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.			N	146.00		
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.				N	147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.				N	148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				N	149.00	
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
				1.00			
165.00	Multi campus Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						
						0.00	
				1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.				Y	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)				0	168.00	
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)				1.00	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)			07/01/2018	09/30/2018	170.00	
				1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)			N	0	171.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0307		Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 10:23 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	02/27/2019			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					1.00
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			N			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N			14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N			15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	03/23/2019	Y	03/23/2019		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0307	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 10:23 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				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.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				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.	MELINDA		HERNANDEZ	41.00
42.00	Enter the employer/company name of the cost report preparer.	BJC HEALTHCARE			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-362-0616		MELINDA.HERNANDEZ@BJC.ORG	43.00

		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: 14-0307

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2019 10:23 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	88	32,120	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)		88	32,120	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	6	2,190	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)		94	34,310	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						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)		94			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0307

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2019 10:23 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents			
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll		
	6.00	7.00	8.00	9.00	10.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	5,294	1,118	13,871			1.00
2.00	HMO and other (see instructions)	2,306	1,799				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	5,294	1,118	13,871			7.00
8.00	INTENSIVE CARE UNIT	514	83	989			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		1,280	2,934			13.00
14.00	Total (see instructions)	5,808	2,481	17,794	0.00	505.12	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
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	505.12	27.00
28.00	Observation Bed Days		0	1,294			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	181	419			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0307

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2019 10:23 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,358	430	5,410	1.00
2.00	HMO and other (see instructions)			529	854		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,358	430	5,410	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						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

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0307

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

Worksheet S-3
Part II
Date/Time Prepared:
5/29/2019 10:23 am

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	31,287,424	36,625	31,324,049	1,060,367.00	29.54
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		132,809	0	132,809	9,669.00	13.74
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		501,921	0	501,921	4,619.00	108.66
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		284,257	0	284,257	1,793.00	158.54
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		5,251,614	0	5,251,614	115,372.00	45.52
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		7,025,314	0	7,025,314		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		29,821	0	29,821		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	196,061	0	196,061	6,050.00	32.41
27.00	Administrative & General	5.00	3,795,880	500	3,796,380	133,067.00	28.53

5/29/2019 10:23 am

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0307

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

Worksheet S-3
Part II
Date/Time Prepared:
5/29/2019 10:23 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		7,195	0	7,195	24.00	299.79	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	186,004	0	186,004	6,650.00	27.97	30.00
31.00	Laundry & Linen Service	8.00	0	36,495	36,495	2,746.00	13.29	31.00
32.00	Housekeeping	9.00	854,888	-36,495	818,393	60,667.00	13.49	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	467,828	0	467,828	33,067.00	14.15	34.00
35.00	Dietary under contract (see instructions)		249,764	0	249,764	7,545.00	33.10	35.00
36.00	Cafeteria	11.00	107,188	0	107,188	7,317.00	14.65	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,331,372	500	1,331,872	31,945.00	41.69	38.00
39.00	Central Services and Supply	14.00	207,651	0	207,651	9,857.00	21.07	39.00
40.00	Pharmacy	15.00	1,462,460	0	1,462,460	33,655.00	43.45	40.00
41.00	Medical Records & Medical Records Library	16.00	149,314	0	149,314	7,864.00	18.99	41.00
42.00	Social Service	17.00	214,811	0	214,811	7,756.00	27.70	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0307

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

Worksheet S-3
Part III
Date/Time Prepared:
5/29/2019 10:23 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	31,544,383	36,625	31,581,008	1,067,936.00	29.57	1.00
2.00	Excluded area salaries (see instructions)	132,809	0	132,809	9,669.00	13.74	2.00
3.00	Subtotal salaries (line 1 minus line 2)	31,411,574	36,625	31,448,199	1,058,267.00	29.72	3.00
4.00	Subtotal other wages & related costs (see inst.)	6,037,792	0	6,037,792	121,784.00	49.58	4.00
5.00	Subtotal wage-related costs (see inst.)	7,025,314	0	7,025,314	0.00	22.34	5.00
6.00	Total (sum of lines 3 thru 5)	44,474,680	36,625	44,511,305	1,180,051.00	37.72	6.00
7.00	Total overhead cost (see instructions)	9,230,416	1,000	9,231,416	348,210.00	26.51	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 14-0307	Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part IV Date/Time Prepared: 5/29/2019 10:23 am
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		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	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	1,134,252	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)	2,797,735	8.02
8.03	Health Insurance (Purchased)	10,381	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	120,386	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	16,048	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)	260,463	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	30,912	14.00
15.00	'Workers' Compensation Insurance	228,183	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	2,272,214	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	11,254	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	143,486	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	7,025,314	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: 14-0307

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

Worksheet S-3
Part V
Date/Time Prepared:
5/29/2019 10:23 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	426,757	7,025,314	1.00
2.00	Hospital	426,757	7,025,314	2.00
3.00	Subprovider - IPF			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: 14-0307	Period: From 01/01/2018 To 12/31/2018	Worksheet S-10 Date/Time Prepared: 5/29/2019 10:23 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)		0.241116	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		6,726,524	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	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		50,055,587	6.00	
7.00	Medicaid cost (line 1 times line 6)		12,069,203	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)		5,342,679	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		0	9.00	
10.00	Stand-alone CHIP charges		0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		5,342,679	19.00	
			Uninsured patients	Insured patients	Total (col. 1 + col. 2)
			1.00	2.00	3.00
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	2,226,503	1,183,357	3,409,860	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	536,845	1,183,357	1,720,202	21.00
22.00	Payments received from patients for amounts previously written off as charity care	250	7,492	7,742	22.00
23.00	Cost of charity care (line 21 minus line 22)	536,595	1,175,865	1,712,460	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)		5,360,364	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		173,398	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		266,767	27.01	
28.00	Non-Medicare bad debt expense (see instructions)		5,093,597	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		1,321,517	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		3,033,977	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		8,376,656	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0307

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

Worksheet A
Date/Time Prepared:
5/29/2019 10:23 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (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			0	9,209,676	9,209,676	1.00
1.01	00101			0	1,000,474	1,000,474	1.01
2.00	00200			0	6,919,397	6,919,397	2.00
4.00	00400	196,061	856,323	1,052,384	6,900,718	7,953,102	4.00
5.00	00500	3,795,880	19,010,655	22,806,535	-9,840,807	12,965,728	5.00
7.00	00700	186,004	2,631,267	2,817,271	-73,345	2,743,926	7.00
8.00	00800	0	0	0	261,052	261,052	8.00
9.00	00900	854,888	763,878	1,618,766	-583,992	1,034,774	9.00
10.00	01000	467,828	806,248	1,274,076	-287,521	986,555	10.00
11.00	01100	107,188	143,281	250,469	-32,503	217,966	11.00
13.00	01300	1,331,372	420,419	1,751,791	-284,488	1,467,303	13.00
14.00	01400	207,651	919,994	1,127,645	-404,509	723,136	14.00
15.00	01500	1,462,460	2,668,766	4,131,226	-2,610,420	1,520,806	15.00
16.00	01600	149,314	578,032	727,346	-35,013	692,333	16.00
17.00	01700	214,811	79,575	294,386	-46,599	247,787	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	8,325,361	6,426,395	14,751,756	-4,990,888	9,760,868	30.00
31.00	03100	1,089,385	469,544	1,558,929	-430,119	1,128,810	31.00
43.00	04300	558	55	613	2,038,883	2,039,496	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	2,888,477	4,163,577	7,052,054	-3,343,482	3,708,572	50.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	2,358,738	2,358,738	-178,226	2,180,512	53.00
54.00	05400	2,796,631	2,812,018	5,608,649	-2,143,033	3,465,616	54.00
57.00	05700	299,964	285,938	585,902	-306,457	279,445	57.00
58.00	05800	141,708	486,729	628,437	-486,516	141,921	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	1,190,502	5,972,790	7,163,292	-530,057	6,633,235	60.00
65.00	06500	894,227	496,725	1,390,952	-347,253	1,043,699	65.00
66.00	06600	917,944	244,634	1,162,578	-232,846	929,732	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	2,738,823	2,738,823	71.00
72.00	07200	0	0	0	2,188,890	2,188,890	72.00
73.00	07300	0	0	0	2,039,786	2,039,786	73.00
74.00	07400	0	236,071	236,071	-1,069	235,002	74.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	3,636,401	1,902,097	5,538,498	-1,217,212	4,321,286	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		3,782,015	3,782,015	-3,238,055	543,960	113.00
118.00		31,154,615	58,515,764	89,670,379	1,653,289	91,323,668	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
193.00	19300	0	0	0	0	0	193.00
194.00	07952	0	9,915	9,915	-9,508	407	194.00
194.01	07951	132,809	1,858,026	1,990,835	-1,643,781	347,054	194.01
200.00		31,287,424	60,383,705	91,671,129	0	91,671,129	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0307

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

Worksheet A
Date/Time Prepared:
5/29/2019 10:23 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100			
		956,567	10,166,243	1.00
1.01	00101		1,000,474	1.01
		0	7,081,059	2.00
2.00	00200	161,662	8,466,528	4.00
4.00	00400	513,426	14,136,333	5.00
5.00	00500	1,170,605	2,546,264	7.00
7.00	00700	-197,662	261,052	8.00
8.00	00800	0	1,034,774	9.00
9.00	00900	0	986,555	10.00
10.00	01000	0	-127,023	11.00
11.00	01100	-344,989	1,455,915	13.00
13.00	01300	-11,388	651,402	14.00
14.00	01400	-71,734	1,520,686	15.00
15.00	01500	-120	281,452	16.00
16.00	01600	-410,881	247,787	17.00
17.00	01700	0		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	-3,151,080	6,609,788	30.00
31.00	03100	0	1,128,810	31.00
43.00	04300	0	2,039,496	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	-429,840	3,278,732	50.00
52.00	05200	0	0	52.00
53.00	05300	-1,962,928	217,584	53.00
54.00	05400	-87,586	3,378,030	54.00
57.00	05700	0	279,445	57.00
58.00	05800	0	141,921	58.00
59.00	05900	0	0	59.00
60.00	06000	-44,813	6,588,422	60.00
65.00	06500	0	1,043,699	65.00
66.00	06600	0	929,732	66.00
67.00	06700	0	0	67.00
68.00	06800	0	0	68.00
69.00	06900	0	0	69.00
71.00	07100	0	2,738,823	71.00
72.00	07200	0	2,188,890	72.00
73.00	07300	0	2,039,786	73.00
74.00	07400	0	235,002	74.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100	-473,678	3,847,608	91.00
92.00	09200			92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	-543,960	0	113.00
118.00		-4,928,399	86,395,269	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	0	0	190.00
192.00	19200	0	0	192.00
193.00	19300	0	0	193.00
194.00	07952	0	407	194.00
194.01	07951	0	347,054	194.01
200.00		-4,928,399	86,742,730	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - EQUIPMENT RENTAL					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	662,345	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
		0.00	0	662,345	
B - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,738,823	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,188,890	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
6.00		0.00	0	0	6.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
		0.00	0	4,927,713	
C - DRUGS SOLD					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,039,786	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
		0.00	0	2,039,786	
D - NURSING FLOAT					
1.00		0.00	0	0	1.00
		0.00	0	0	
F - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	6,525,242	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.01	0	994,329	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	5,655,300	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

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
20.00		0.00	0	0	20.00
			0	13,174,871	
H - NURSERY/OB					
1.00		43.00	1,670,505	368,378	1.00
			1,670,505	368,378	
I - INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	38,149	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.01	0	6,145	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	9,982	3.00
			0	54,276	
J - INTEREST					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,646,285	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	591,770	2.00
			0	3,238,055	
K - HOUSEKEEPING					
1.00	LAUNDRY & LINEN SERVICE	8.00	36,495	24,141	1.00
			36,495	24,141	
M - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6,937,537	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
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
			0	6,937,537	
O - RECRUITMENT RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	500	0	1.00
2.00	NURSING ADMINISTRATION	13.00	500	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	11,375	0	3.00
4.00	INTENSIVE CARE UNIT	31.00	750	0	4.00
5.00	OPERATING ROOM	50.00	7,250	0	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	1,000	0	6.00
7.00	LABORATORY	60.00	4,250	0	7.00
8.00	RESPIRATORY THERAPY	65.00	1,500	0	8.00
9.00	EMERGENCY	91.00	9,500	0	9.00
	TOTALS		36,625	0	
P - RECLASS LAUNDRY EXPENSE					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	200,416	1.00
	TOTALS		0	200,416	
500.00	Grand Total: Increases		1,743,625	31,627,518	500.00

RECLASSIFICATIONS

Provider CCN: 14-0307

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

Worksheet A-6
Date/Time Prepared:
5/29/2019 10:23 am

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
A - EQUIPMENT RENTAL						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	62,339	14	1.00
2.00	CAFETERIA	11.00	0	5,676	0	2.00
3.00	NURSING ADMINISTRATION	13.00	0	1,854	0	3.00
4.00	PHARMACY	15.00	0	364,360	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	0	75,927	0	5.00
6.00	INTENSIVE CARE UNIT	31.00	0	3,376	0	6.00
7.00	OPERATING ROOM	50.00	0	4,050	0	7.00
8.00	LABORATORY	60.00	0	118,083	0	8.00
9.00	RESPIRATORY THERAPY	65.00	0	26,366	0	9.00
10.00	PHYSICAL THERAPY	66.00	0	314	0	10.00
	O		0	662,345		
B - MEDICAL SUPPLIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	194	0	1.00
2.00		0.00	0	0	0	2.00
3.00	OPERATION OF PLANT	7.00	0	12,397	0	3.00
4.00	HOUSEKEEPING	9.00	0	75,337	0	4.00
6.00	CAFETERIA	11.00	0	403	0	6.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	279,763	0	8.00
9.00	PHARMACY	15.00	0	197,301	0	9.00
10.00	SOCIAL SERVICE	17.00	0	4	0	10.00
11.00	ADULTS & PEDIATRICS	30.00	0	761,982	0	11.00
12.00	INTENSIVE CARE UNIT	31.00	0	136,693	0	12.00
13.00	OPERATING ROOM	50.00	0	2,375,356	0	13.00
14.00	ANESTHESIOLOGY	53.00	0	60,744	0	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	593,298	0	15.00
16.00	CT SCAN	57.00	0	9,647	0	16.00
17.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	3,861	0	17.00
18.00	LABORATORY	60.00	0	79,368	0	18.00
19.00	RESPIRATORY THERAPY	65.00	0	5,464	0	19.00
20.00	PHYSICAL THERAPY	66.00	0	7,579	0	20.00
21.00	RENAL DIALYSIS	74.00	0	1,069	0	21.00
22.00	EMERGENCY	91.00	0	287,279	0	22.00
23.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	0	9,508	0	23.00
24.00	MEDICAL OFFICE BUILDING 1	194.01	0	30,466	0	24.00
	O		0	4,927,713		
C - DRUGS SOLD						
1.00	PHARMACY	15.00	0	1,754,236	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	1,242	0	2.00
3.00	INTENSIVE CARE UNIT	31.00	0	84	0	3.00
4.00	OPERATING ROOM	50.00	0	148	0	4.00
5.00	ANESTHESIOLOGY	53.00	0	48,475	0	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	96,527	0	6.00
7.00	CT SCAN	57.00	0	105,661	0	7.00
8.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	25,385	0	8.00
9.00	LABORATORY	60.00	0	1,307	0	9.00
10.00	RESPIRATORY THERAPY	65.00	0	6,699	0	10.00
11.00	EMERGENCY	91.00	0	22	0	11.00
	O		0	2,039,786		
D - NURSING FLOAT						
1.00		0.00	0	0	0	1.00
	O		0	0		
F - DEPRECIATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	8,818,691	9	1.00
2.00	OPERATION OF PLANT	7.00	0	17,532	9	2.00
3.00	HOUSEKEEPING	9.00	0	2,225	9	3.00
4.00	DIETARY	10.00	0	142,072	0	4.00
5.00	CAFETERIA	11.00	0	3,019	0	5.00
6.00	NURSING ADMINISTRATION	13.00	0	35,448	0	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	60,963	0	7.00
8.00	PHARMACY	15.00	0	3,510	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	259,157	0	9.00
10.00	INTENSIVE CARE UNIT	31.00	0	74,230	0	10.00
11.00	OPERATING ROOM	50.00	0	399,659	0	11.00
12.00	ANESTHESIOLOGY	53.00	0	69,007	0	12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	834,911	0	13.00
14.00	CT SCAN	57.00	0	115,532	0	14.00
15.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	433,136	0	15.00
16.00	LABORATORY	60.00	0	84,569	0	16.00
17.00	RESPIRATORY THERAPY	65.00	0	38,647	0	17.00

5/29/2019 10:23 am

RECLASSIFICATIONS

Provider CCN: 14-0307

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

Worksheet A-6
Date/Time Prepared:
5/29/2019 10:23 am

Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
18.00	PHYSICAL THERAPY	66.00	0	3,760	0	18.00	
19.00	EMERGENCY	91.00	0	165,488	0	19.00	
20.00	MEDICAL OFFICE BUILDING 1	194.01	0	1,613,315	0	20.00	
			0	13,174,871			
H - NURSERY/OB							
1.00	ADULTS & PEDIATRICS	30.00	1,670,505	368,378	0	1.00	
			1,670,505	368,378			
I - INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	54,276	12	1.00	
2.00		0.00	0	0	12	2.00	
3.00		0.00	0	0	12	3.00	
			0	54,276			
J - INTEREST							
1.00	INTEREST EXPENSE	113.00	0	3,238,055	14	1.00	
2.00		0.00	0	0	14	2.00	
			0	3,238,055			
K - HOUSEKEEPING							
1.00	HOUSEKEEPING	9.00	36,495	24,141	0	1.00	
			36,495	24,141			
M - EMPLOYEE BENEFITS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	906,001	0	1.00	
2.00	OPERATION OF PLANT	7.00	0	43,416	0	2.00	
3.00	HOUSEKEEPING	9.00	0	245,378	0	3.00	
4.00	DIETARY	10.00	0	145,449	0	4.00	
5.00	CAFETERIA	11.00	0	23,405	0	5.00	
6.00	NURSING ADMINISTRATION	13.00	0	247,686	0	6.00	
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	63,783	0	7.00	
8.00	PHARMACY	15.00	0	291,013	0	8.00	
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	35,013	0	9.00	
10.00	SOCIAL SERVICE	17.00	0	46,595	0	10.00	
11.00	ADULTS & PEDIATRICS	30.00	0	1,865,072	0	11.00	
12.00	INTENSIVE CARE UNIT	31.00	0	216,486	0	12.00	
13.00	OPERATING ROOM	50.00	0	571,519	0	13.00	
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	619,297	0	14.00	
15.00	CT SCAN	57.00	0	75,617	0	15.00	
16.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	24,134	0	16.00	
17.00	LABORATORY	60.00	0	250,980	0	17.00	
18.00	RESPIRATORY THERAPY	65.00	0	271,577	0	18.00	
19.00	PHYSICAL THERAPY	66.00	0	221,193	0	19.00	
20.00	EMERGENCY	91.00	0	773,923	0	20.00	
			0	6,937,537			
O - RECRUITMENT RECLASS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36,625	0	1.00	
2.00		0.00	0	0	0	2.00	
3.00		0.00	0	0	0	3.00	
4.00		0.00	0	0	0	4.00	
5.00		0.00	0	0	0	5.00	
6.00		0.00	0	0	0	6.00	
7.00		0.00	0	0	0	7.00	
8.00		0.00	0	0	0	8.00	
9.00		0.00	0	0	0	9.00	
	TOTALS		0	36,625			
P - RECLASS LAUNDRY EXPENSE							
1.00	HOUSEKEEPING	9.00	0	200,416	0	1.00	
	TOTALS		0	200,416			
500.00	Grand Total: Decreases		1,707,000	31,664,143		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0307

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

Worksheet A-7
Part I
Date/Time Prepared:
5/29/2019 10:23 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	9,200,000	0	0	0	0	1.00
2.00	Land Improvements	5,407,323	1,752,254	0	1,752,254	0	2.00
3.00	Buildings and Fixtures	99,427,731	14,003,721	0	14,003,721	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	25,594,356	4,537,375	0	4,537,375	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	139,629,410	20,293,350	0	20,293,350	0	8.00
9.00	Reconciling Items	6,186,698	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	133,442,712	20,293,350	0	20,293,350	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	9,200,000	0				1.00
2.00	Land Improvements	7,159,577	0				2.00
3.00	Buildings and Fixtures	113,431,452	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	30,131,731	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	159,922,760	0				8.00
9.00	Reconciling Items	6,186,698	0				9.00
10.00	Total (line 8 minus line 9)	153,736,062	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0307

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

Worksheet A-7
Part II
Date/Time Prepared:
5/29/2019 10:23 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
1.01	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.01
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
1.01	CAP REL COSTS-BLDG & FIXT	0	0				1.01
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: 14-0307

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

Worksheet A-7
Part III
Date/Time Prepared:
5/29/2019 10:23 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	104,725,216	0	104,725,216	0.694820	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT	16,869,275	0	16,869,275	0.111923	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	29,128,271	0	29,128,271	0.193257	0	2.00
3.00	Total (sum of lines 1-2)	150,722,762	0	150,722,762	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	6,525,242	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT	0	0	0	994,329	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	5,533,184	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	13,052,755	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	689,570	38,149	0	2,913,282	10,166,243	1.00
1.01	CAP REL COSTS-BLDG & FIXT	0	6,145	0	0	1,000,474	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	129,881	9,982	0	1,408,012	7,081,059	2.00
3.00	Total (sum of lines 1-2)	819,451	54,276	0	4,321,294	18,247,776	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0307

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

Worksheet A-8

Date/Time Prepared:
5/29/2019 10:23 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
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-31,726	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			CAP REL COSTS-BLDG & FIXT	1.01		1.01
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-6,945	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-8,423	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)		0		0.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-6,728,053				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	1,658,800				12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-124,496	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employee and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients		0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	0		0.00	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		RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01 Depreciation - CAP REL COSTS-BLDG & FIXT			CAP REL COSTS-BLDG & FIXT	1.01	0	26.01
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			*** 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		OCCUPATIONAL THERAPY	67.00		30.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0307

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

Worksheet A-8

Date/Time Prepared:
5/29/2019 10:23 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.	
			Cost Center		Line #		
			1.00	2.00	3.00		4.00
30.99 Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS		30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0SPEECH PATHOLOGY		68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0	32.00
33.00 MISC INCOME	B	-340	ADULTS & PEDIATRICS		30.00	0	33.00
33.01 MISC. INCOME	B	-1,375	RADIOLOGY-DIAGNOSTIC		54.00	0	33.01
33.02 MISC INCOME	B	-695	ADMINISTRATIVE & GENERAL		5.00	0	33.02
33.03 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.03
33.04 COFFEE BAR	B	-220,493	CAFETERIA		11.00	0	33.04
33.05 ALCOHOLIC BEVERAGES	A	-120	PHARMACY		15.00	0	33.05
33.06 CONTRIBUTION	A	-15,745	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	33.06
33.07 CONTRIBUTION	A	-228	ADMINISTRATIVE & GENERAL		5.00	0	33.07
33.08 CONTRIBUTION	A	-217	RADIOLOGY-DIAGNOSTIC		54.00	0	33.08
33.09 CONTRIBUTION	A	-205	LABORATORY		60.00	0	33.09
33.10 CONTRIBUTION	A	-118	EMERGENCY		91.00	0	33.10
33.11 ADVERTISING	A	-25,887	ADMINISTRATIVE & GENERAL		5.00	0	33.11
33.12 MEMBERSHIP DUES	A	-27,477	ADMINISTRATIVE & GENERAL		5.00	0	33.12
33.13 LOBBY EXPENSE	A	-10,433	ADMINISTRATIVE & GENERAL		5.00	0	33.13
33.14 ENTERTAINMENT EXPENSE	A	-43	RADIOLOGY-DIAGNOSTIC		54.00	0	33.14
33.15 AMORTIZED CAPITAL START UP	A	96,285	CAP REL COSTS-BLDG & FIXT		1.00	11	33.15
33.16 AMORTIZED START UP COSTS	A	1,309,797	ADMINISTRATIVE & GENERAL		5.00	11	33.16
33.17 INTEREST RATE SWAP	A	-356,168	INTEREST EXPENSE		113.00	11	33.17
33.18 AMORTIZATION LOSS ON FINANCING	A	625,011	CAP REL COSTS-BLDG & FIXT		1.00	11	33.18
33.19 AMORTIZATION LOSS ON FINANCING	A	136,826	CAP REL COSTS-MVBLE EQUIP		2.00	11	33.19
33.20 MALPRACTICE INSURANCE	A	-885,780	ADMINISTRATIVE & GENERAL		5.00	0	33.20
33.21 RENT EXPENSE	A	-188,035	ADMINISTRATIVE & GENERAL		5.00	0	33.21
33.22 UNASSIGNED DEPRECIATION	A	-122,116	CAP REL COSTS-MVBLE EQUIP		2.00	9	33.22
33.23 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.23
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,928,399					50.00

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

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

Provider CCN: 14-0307

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

Worksheet A-8-1

Date/Time Prepared: 5/29/2019 10:23 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	OTHER EXP.	266,997	0 1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	OTHER EXP.	153,897	0 2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	SALARY	275,065	0 3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	SALARY	1,833,234	0 3.01
3.02	14.00	CENTRAL SERVICES & SUPPLY	SALARY	324,507	0 3.02
3.03	7.00	OPERATION OF PLANT	SALARY	205,513	0 3.03
3.04	5.00	ADMINISTRATIVE & GENERAL	SALARY	15,920	0 3.04
3.05	5.00	ADMINISTRATIVE & GENERAL	SALARY	2,430,105	0 3.05
3.06	4.00	EMPLOYEE BENEFITS DEPARTMENT	OTHER EXP.	85,028	0 3.06
3.07	5.00	ADMINISTRATIVE & GENERAL	OTHER EXP.	1,376,611	0 3.07
3.08	14.00	CENTRAL SERVICES & SUPPLY	OTHER EXP.	48,640	0 3.08
3.09	5.00	ADMINISTRATIVE & GENERAL	OTHER EXP.	24,087	0 3.09
3.10	7.00	OPERATION OF PLANT	OTHER EXP.	743,129	0 3.10
3.11	5.00	ADMINISTRATIVE & GENERAL	OTHER EXP.	628,515	0 3.11
3.12	4.00	EMPLOYEE BENEFITS DEPARTMENT	OTHER EXP.	651,038	0 3.12
3.13	60.00	LABORATORY	REFERENCE LAB CHRISTIAN	48,223	34,524 3.13
3.14	5.00	ADMINISTRATIVE & GENERAL	BJC OVERHEAD ALLOCATION	0	57,494 3.14
3.15	4.00	EMPLOYEE BENEFITS DEPARTMENT	OTHER EXP.	0	475,596 3.15
3.16	5.00	ADMINISTRATIVE & GENERAL	OTHER EXP.	0	4,693,002 3.16
3.17	7.00	OPERATION OF PLANT	OTHER EXP.	0	1,146,304 3.17
3.18	14.00	CENTRAL SERVICES & SUPPLY	OTHER EXP.	0	444,881 3.18
3.19	16.00	MEDICAL RECORDS & LIBRARY	OTHER EXP.	0	410,881 3.19
3.20	113.00	INTEREST EXPENSE	OTHER EXP.	0	187,792 3.20
3.22	50.00	OPERATING ROOM	MIDWEST SURGICAL TECHNOLOGIE	6,292	7,640 3.22
4.00	5.00	ADMINISTRATIVE & GENERAL	TFC TELEPHONE EXPENSE	6,095	5,982 4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			9,122,896	7,464,096 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.

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	BJC HEALTHCARE	1.00	BJC HEALTHCARE	1.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-0307

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

Worksheet A-8-1

Date/Time Prepared:
5/29/2019 10:23 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	266,997	14	1.00
2.00	153,897	14	2.00
3.00	275,065	0	3.00
3.01	1,833,234	0	3.01
3.02	324,507	0	3.02
3.03	205,513	0	3.03
3.04	15,920	0	3.04
3.05	2,430,105	0	3.05
3.06	85,028	0	3.06
3.07	1,376,611	0	3.07
3.08	48,640	0	3.08
3.09	24,087	0	3.09
3.10	743,129	0	3.10
3.11	628,515	0	3.11
3.12	651,038	0	3.12
3.13	13,699	0	3.13
3.14	-57,494	0	3.14
3.15	-475,596	0	3.15
3.16	-4,693,002	0	3.16
3.17	-1,146,304	0	3.17
3.18	-444,881	0	3.18
3.19	-410,881	0	3.19
3.20	-187,792	0	3.20
3.22	-1,348	0	3.22
4.00	113	0	4.00
5.00	1,658,800		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		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: 14-0307

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

Worksheet A-8-2

Date/Time Prepared:
5/29/2019 10:23 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	4.00 EMPLOYEE BENEFITS DEPARTMENT	11,527	0	11,527	179,000	60
2.00	5.00 ADMINISTRATIVE & GENERAL	646,938	522,488	124,450	179,000	1,084
3.00	13.00 NURSING ADMINISTRATION	28,600	0	28,600	179,000	200
4.00	30.00 ADULTS & PEDIATRICS	3,150,740	3,150,740	0	0	0
5.00	50.00 OPERATING ROOM	428,492	428,492	0	0	0
6.00	53.00 ANESTHESIOLOGY	1,962,928	1,962,928	0	0	0
7.00	54.00 RADIOLOGY-DIAGNOSTIC	119,427	15,747	103,680	179,000	389
8.00	60.00 LABORATORY	63,643	47,643	16,000	179,000	62
9.00	91.00 EMERGENCY	473,560	473,560	0	0	0
10.00	0.00	0	0	0	0	0
200.00		6,885,855	6,601,598	284,257		1,795

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	4.00 EMPLOYEE BENEFITS DEPARTMENT	5,163	258	0	0	0
2.00	5.00 ADMINISTRATIVE & GENERAL	93,287	4,664	0	0	17,301
3.00	13.00 NURSING ADMINISTRATION	17,212	861	0	0	0
4.00	30.00 ADULTS & PEDIATRICS	0	0	0	0	44,958
5.00	50.00 OPERATING ROOM	0	0	0	0	0
6.00	53.00 ANESTHESIOLOGY	0	0	0	0	0
7.00	54.00 RADIOLOGY-DIAGNOSTIC	33,476	1,674	0	0	0
8.00	60.00 LABORATORY	5,336	267	0	0	0
9.00	91.00 EMERGENCY	0	0	0	0	157,508
10.00	0.00	0	0	0	0	0
200.00		154,474	7,724	0	0	219,767

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	4.00 EMPLOYEE BENEFITS DEPARTMENT	0	5,163	6,364	6,364
2.00	5.00 ADMINISTRATIVE & GENERAL	3,328	96,615	27,835	550,323
3.00	13.00 NURSING ADMINISTRATION	0	17,212	11,388	11,388
4.00	30.00 ADULTS & PEDIATRICS	0	0	0	3,150,740
5.00	50.00 OPERATING ROOM	0	0	0	428,492
6.00	53.00 ANESTHESIOLOGY	0	0	0	1,962,928
7.00	54.00 RADIOLOGY-DIAGNOSTIC	0	33,476	70,204	85,951
8.00	60.00 LABORATORY	0	5,336	10,664	58,307
9.00	91.00 EMERGENCY	0	0	0	473,560
10.00	0.00	0	0	0	0
200.00		3,328	157,802	126,455	6,728,053

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0307

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2019 10:23 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	BLDG & FIXT	MVBLE EQUIP		
	0	1.00	1.01	2.00	4.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	10,166,243	10,166,243			1.00
1.01 00101	CAP REL COSTS-BLDG & FIXT	1,000,474	0	1,000,474		1.01
2.00 00200	CAP REL COSTS-MVBLE EQUIP	7,081,059			7,081,059	2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	8,466,528	9,629	0	4,845	8,481,002
5.00 00500	ADMINISTRATIVE & GENERAL	14,136,333	2,200,325	0	1,107,005	1,036,768
7.00 00700	OPERATION OF PLANT	2,546,264	872,238	53,394	543,772	50,909
8.00 00800	LAUNDRY & LINEN SERVICE	261,052	0	0	0	9,989
9.00 00900	HOUSEKEEPING	1,034,774	298,734	0	150,296	223,992
10.00 01000	DIETARY	986,555	246,159	0	123,845	128,043
11.00 01100	CAFETERIA	-127,023	85,005	0	42,767	29,337
13.00 01300	NURSING ADMINISTRATION	1,455,915	44,163	0	22,219	364,529
14.00 01400	CENTRAL SERVICES & SUPPLY	651,402	166,633	0	83,835	56,833
15.00 01500	PHARMACY	1,520,686	147,707	0	74,313	400,271
16.00 01600	MEDICAL RECORDS & LIBRARY	281,452	33,150	0	16,678	40,867
17.00 01700	SOCIAL SERVICE	247,787	5,811	0	2,924	58,793
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	6,609,788	2,673,825	0	1,345,227	1,824,531
31.00 03100	INTENSIVE CARE UNIT	1,128,810	266,802	0	134,231	298,367
43.00 04300	NURSERY	2,039,496	88,104	0	44,326	457,365
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	3,278,732	986,906	0	496,522	792,552
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00 05300	ANESTHESIOLOGY	217,584	89,543	0	45,050	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,378,030	660,999	99,280	527,678	765,703
57.00 05700	CT SCAN	279,445	57,832	0	29,096	82,099
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	141,921	59,769	0	30,070	38,785
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00 06000	LABORATORY	6,588,422	134,757	19,380	105,887	327,000
65.00 06500	RESPIRATORY THERAPY	1,043,699	69,398	0	34,915	245,158
66.00 06600	PHYSICAL THERAPY	929,732	36,027	105,400	225,277	251,239
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,738,823	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	2,188,890	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	2,039,786	0	0	0	0
74.00 07400	RENAL DIALYSIS	235,002	6,918	0	3,480	0
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	3,847,608	477,653	0	240,312	997,872
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	86,395,269	9,718,087	277,454	5,434,570	8,481,002
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22,635	0	11,388	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	413,180	502,389	1,195,267	0
193.00 19300	NONPAID WORKERS	0	0	0	0	0
194.00 07952	OTHER NONREIMBURSABLE COST CENTERS	407	12,341	220,631	439,834	0
194.01 07951	MEDICAL OFFICE BUILDING 1	347,054	0	0	0	0
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	86,742,730	10,166,243	1,000,474	7,081,059	8,481,002

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0307

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2019 10:23 am

Cost Center Description		Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4A	5.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	18,480,431	18,480,431				5.00
7.00	00700	4,066,577	1,100,932	5,167,509			7.00
8.00	00800	271,041	73,378	0	344,419		8.00
9.00	00900	1,707,796	462,346	143,151	0	2,313,293	9.00
10.00	01000	1,484,602	401,922	117,957	0	54,309	10.00
11.00	01100	30,086	8,145	40,734	0	18,754	11.00
13.00	01300	1,886,826	510,815	21,162	0	9,743	13.00
14.00	01400	958,703	259,547	79,849	0	36,764	14.00
15.00	01500	2,142,977	580,162	70,780	0	32,588	15.00
16.00	01600	372,147	100,750	15,885	0	7,314	16.00
17.00	01700	315,315	85,364	2,785	0	1,282	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	12,453,371	3,371,448	1,281,276	146,652	589,921	30.00
31.00	03100	1,828,210	494,946	127,849	12,171	58,864	31.00
43.00	04300	2,629,291	711,820	42,219	26,334	19,438	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	5,554,712	1,503,811	472,917	38,214	217,739	50.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	352,177	95,344	42,908	0	19,756	53.00
54.00	05400	5,431,690	1,470,505	502,592	53,789	231,401	54.00
57.00	05700	448,472	121,413	27,713	0	12,759	57.00
58.00	05800	270,545	73,244	28,641	0	13,187	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	7,175,446	1,942,587	100,853	0	46,434	60.00
65.00	06500	1,393,170	377,169	33,255	0	15,311	65.00
66.00	06600	1,547,675	418,997	214,567	0	98,790	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	2,738,823	741,473	0	0	0	71.00
72.00	07200	2,188,890	592,592	0	0	0	72.00
73.00	07300	2,039,786	552,225	0	0	0	73.00
74.00	07400	245,400	66,436	3,315	0	1,526	74.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	5,563,445	1,506,175	228,887	67,259	105,383	91.00
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		83,577,604	17,623,546	3,599,295	344,419	1,591,263	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	34,023	9,211	10,846	0	4,994	190.00
192.00	19200	2,110,836	571,460	1,138,444	0	524,157	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07952	673,213	182,257	418,924	0	192,879	194.00
194.01	07951	347,054	93,957	0	0	0	194.01
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		86,742,730	18,480,431	5,167,509	344,419	2,313,293	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0307

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2019 10:23 am

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	2,058,790					10.00
11.00	01100	0	97,719				11.00
13.00	01300	0	3,870	2,432,416			13.00
14.00	01400	0	1,195	0	1,336,058		14.00
15.00	01500	0	4,134	0	0	2,830,641	15.00
16.00	01600	0	979	0	0	0	16.00
17.00	01700	0	935	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,925,526	29,568	931,974	0	0	30.00
31.00	03100	133,264	3,465	170,973	0	0	31.00
43.00	04300	0	5,925	347,176	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	9,578	414,527	0	0	50.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	10,673	77,141	0	0	54.00
57.00	05700	0	1,245	293	0	0	57.00
58.00	05800	0	465	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	5,445	0	0	0	60.00
65.00	06500	0	3,690	0	0	0	65.00
66.00	06600	0	3,298	0	0	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	742,582	0	71.00
72.00	07200	0	0	0	593,476	0	72.00
73.00	07300	0	0	0	0	2,830,641	73.00
74.00	07400	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	0	13,254	490,332	0	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00							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
193.00	19300	0	0	0	0	0	193.00
194.00	07952	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		2,058,790	97,719	2,432,416	1,336,058	2,830,641	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0307

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2019 10:23 am

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT					1.01
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
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	497,075				16.00
17.00	01700	SOCIAL SERVICE	0	405,681			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	65,330	379,422	21,174,488	0	21,174,488
31.00	03100	INTENSIVE CARE UNIT	7,436	26,259	2,863,437	0	2,863,437
43.00	04300	NURSERY	8,364	0	3,790,567	0	3,790,567
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	45,269	0	8,256,767	0	8,256,767
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	16,163	0	526,348	0	526,348
54.00	05400	RADIOLOGY-DIAGNOSTIC	81,929	0	7,859,720	0	7,859,720
57.00	05700	CT SCAN	64,109	0	676,004	0	676,004
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	11,326	0	397,408	0	397,408
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	80,378	0	9,351,143	0	9,351,143
65.00	06500	RESPIRATORY THERAPY	17,534	0	1,840,129	0	1,840,129
66.00	06600	PHYSICAL THERAPY	9,198	0	2,292,525	0	2,292,525
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,774	0	4,229,652	0	4,229,652
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,803	0	3,380,761	0	3,380,761
73.00	07300	DRUGS CHARGED TO PATIENTS	35,617	0	5,458,269	0	5,458,269
74.00	07400	RENAL DIALYSIS	879	0	317,556	0	317,556
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	40,966	0	8,015,701	0	8,015,701
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	497,075	405,681	80,430,475	0	80,430,475
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	59,074	0	59,074
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	4,344,897	0	4,344,897
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	1,467,273	0	1,467,273
194.01	07951	MEDICAL OFFICE BUILDING 1	0	0	441,011	0	441,011
200.00		Cross Foot Adjustments			0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	497,075	405,681	86,742,730	0	86,742,730

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0307

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

Worksheet B
Part II
Date/Time Prepared:
5/29/2019 10:23 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
		BLDG & FIXT	BLDG & FIXT	MVBLE EQUIP		
		0	1.00	1.01		
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	CAP REL COSTS-BLDG & FIXT					1.01
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,629	0	4,845	14,474
5.00 00500	ADMINISTRATIVE & GENERAL	0	2,200,325	0	1,107,005	3,307,330
7.00 00700	OPERATION OF PLANT	0	872,238	53,394	543,772	1,469,404
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0
9.00 00900	HOUSEKEEPING	0	298,734	0	150,296	449,030
10.00 01000	DIETARY	0	246,159	0	123,845	370,004
11.00 01100	CAFETERIA	0	85,005	0	42,767	127,772
13.00 01300	NURSING ADMINISTRATION	0	44,163	0	22,219	66,382
14.00 01400	CENTRAL SERVICES & SUPPLY	0	166,633	0	83,835	250,468
15.00 01500	PHARMACY	0	147,707	0	74,313	222,020
16.00 01600	MEDICAL RECORDS & LIBRARY	0	33,150	0	16,678	49,828
17.00 01700	SOCIAL SERVICE	0	5,811	0	2,924	8,735
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	2,673,825	0	1,345,227	4,019,052
31.00 03100	INTENSIVE CARE UNIT	0	266,802	0	134,231	401,033
43.00 04300	NURSERY	0	88,104	0	44,326	132,430
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	986,906	0	496,522	1,483,428
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00 05300	ANESTHESIOLOGY	0	89,543	0	45,050	134,593
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	660,999	99,280	527,678	1,287,957
57.00 05700	CT SCAN	0	57,832	0	29,096	86,928
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	59,769	0	30,070	89,839
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00 06000	LABORATORY	0	134,757	19,380	105,887	260,024
65.00 06500	RESPIRATORY THERAPY	0	69,398	0	34,915	104,313
66.00 06600	PHYSICAL THERAPY	0	36,027	105,400	225,277	366,704
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	6,918	0	3,480	10,398
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0	477,653	0	240,312	717,965
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	9,718,087	277,454	5,434,570	15,430,111
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22,635	0	11,388	34,023
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	413,180	502,389	1,195,267	2,110,836
193.00 19300	NONPAID WORKERS	0	0	0	0	0
194.00 07952	OTHER NONREIMBURSABLE COST CENTERS	0	12,341	220,631	439,834	672,806
194.01 07951	MEDICAL OFFICE BUILDING 1	0	0	0	0	0
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	0	10,166,243	1,000,474	7,081,059	18,247,776

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0307

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

Worksheet B
Part II
Date/Time Prepared:
5/29/2019 10:23 am

Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4.00	5.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	14,474					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,769	3,309,099				5.00
7.00	00700	OPERATION OF PLANT	87	197,131	1,666,622			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17	13,139	0	13,156		8.00
9.00	00900	HOUSEKEEPING	382	82,787	46,169	0	578,368	9.00
10.00	01000	DIETARY	218	71,968	38,044	0	13,578	10.00
11.00	01100	CAFETERIA	50	1,458	13,137	0	4,689	11.00
13.00	01300	NURSING ADMINISTRATION	622	91,466	6,825	0	2,436	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	97	46,474	25,753	0	9,192	14.00
15.00	01500	PHARMACY	683	103,883	22,828	0	8,148	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	70	18,040	5,123	0	1,829	16.00
17.00	01700	SOCIAL SERVICE	100	15,285	898	0	321	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,118	603,705	413,237	5,601	147,490	30.00
31.00	03100	INTENSIVE CARE UNIT	509	88,624	41,234	465	14,717	31.00
43.00	04300	NURSERY	780	127,458	13,616	1,006	4,860	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,352	269,270	152,525	1,460	54,439	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	17,072	13,839	0	4,939	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,306	263,307	162,096	2,055	57,855	54.00
57.00	05700	CT SCAN	140	21,740	8,938	0	3,190	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	66	13,115	9,237	0	3,297	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	558	347,837	32,527	0	11,609	60.00
65.00	06500	RESPIRATORY THERAPY	418	67,535	10,725	0	3,828	65.00
66.00	06600	PHYSICAL THERAPY	429	75,025	69,202	0	24,699	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	132,767	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	106,109	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	98,881	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	11,896	1,069	0	382	74.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	1,703	269,694	73,821	2,569	26,348	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)	14,474	3,155,666	1,160,843	13,156	397,846	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,649	3,498	0	1,249	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	102,325	367,170	0	131,049	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07952	OTHER NONREIMBURSABLE COST CENTERS	0	32,635	135,111	0	48,224	194.00
194.01	07951	MEDICAL OFFICE BUILDING 1	0	16,824	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	14,474	3,309,099	1,666,622	13,156	578,368	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0307		Period: From 01/01/2018 To 12/31/2018		Worksheet B Part II Date/Time Prepared: 5/29/2019 10:23 am	
Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT						1.01
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
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	493,812					10.00
11.00	01100	CAFETERIA	0	63,962				11.00
13.00	01300	NURSING ADMINISTRATION	0	2,533	170,264			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	782	0	332,766		14.00
15.00	01500	PHARMACY	0	2,706	0	0	360,268	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	641	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	612	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	461,848	19,354	65,235	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	31,964	2,268	11,968	0	0	31.00
43.00	04300	NURSERY	0	3,878	24,302	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	6,269	29,016	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,986	5,400	0	0	54.00
57.00	05700	CT SCAN	0	815	21	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	304	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	3,564	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,415	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,159	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	184,950	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	147,816	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	360,268	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	8,676	34,322	0	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)	493,812	63,962	170,264	332,766	360,268	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING 1	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	83,144	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	493,812	147,106	170,264	332,766	360,268	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0307

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

Worksheet B
Part II
Date/Time Prepared:
5/29/2019 10:23 am

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT					1.01
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
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	75,531				16.00
17.00	01700	SOCIAL SERVICE	0	25,951			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,909	24,271	5,772,820	0	5,772,820
31.00	03100	INTENSIVE CARE UNIT	1,128	1,680	595,590	0	595,590
43.00	04300	NURSERY	1,269	0	309,599	0	309,599
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,866	0	2,004,625	0	2,004,625
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	2,452	0	172,895	0	172,895
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,562	0	1,799,524	0	1,799,524
57.00	05700	CT SCAN	9,724	0	131,496	0	131,496
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,718	0	117,576	0	117,576
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	12,192	0	668,311	0	668,311
65.00	06500	RESPIRATORY THERAPY	2,660	0	191,894	0	191,894
66.00	06600	PHYSICAL THERAPY	1,395	0	539,613	0	539,613
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,027	0	318,744	0	318,744
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	880	0	254,805	0	254,805
73.00	07300	DRUGS CHARGED TO PATIENTS	5,402	0	464,551	0	464,551
74.00	07400	RENAL DIALYSIS	133	0	23,878	0	23,878
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	6,214	0	1,141,312	0	1,141,312
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	75,531	25,951	14,507,233	0	14,507,233
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	40,419	0	40,419
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	2,711,380	0	2,711,380
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	888,776	0	888,776
194.01	07951	MEDICAL OFFICE BUILDING 1	0	0	16,824	0	16,824
200.00		Cross Foot Adjustments			0	0	0
201.00		Negative Cost Centers	0	0	83,144	0	83,144
202.00		TOTAL (sum lines 118 through 201)	75,531	25,951	18,247,776	0	18,247,776

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0307

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

Worksheet B-1
Date/Time Prepared:
5/29/2019 10:23 am

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
		BLDG & FIXT (SQUARE FEET)	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)			
		1.00	1.01	2.00			
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	183,700				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT	0	70,622			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			254,322		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	174	0	174	30,986,811	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	39,759	0	39,759	3,788,012	-18,480,431
7.00	00700	OPERATION OF PLANT	15,761	3,769	19,530	186,004	0
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	36,495	0
9.00	00900	HOUSEKEEPING	5,398	0	5,398	818,393	0
10.00	01000	DIETARY	4,448	0	4,448	467,828	0
11.00	01100	CAFETERIA	1,536	0	1,536	107,188	0
13.00	01300	NURSING ADMINISTRATION	798	0	798	1,331,872	0
14.00	01400	CENTRAL SERVICES & SUPPLY	3,011	0	3,011	207,651	0
15.00	01500	PHARMACY	2,669	0	2,669	1,462,460	0
16.00	01600	MEDICAL RECORDS & LIBRARY	599	0	599	149,314	0
17.00	01700	SOCIAL SERVICE	105	0	105	214,811	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	48,315	0	48,315	6,666,231	0
31.00	03100	INTENSIVE CARE UNIT	4,821	0	4,821	1,090,135	0
43.00	04300	NURSERY	1,592	0	1,592	1,671,063	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	17,833	0	17,833	2,895,727	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	1,618	0	1,618	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,944	7,008	18,952	2,797,631	0
57.00	05700	CT SCAN	1,045	0	1,045	299,964	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,080	0	1,080	141,708	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	2,435	1,368	3,803	1,194,752	0
65.00	06500	RESPIRATORY THERAPY	1,254	0	1,254	895,727	0
66.00	06600	PHYSICAL THERAPY	651	7,440	8,091	917,944	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	125	0	125	0	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	8,631	0	8,631	3,645,901	0
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)	175,602	19,585	195,187	30,986,811	-18,480,431
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	409	0	409	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,466	35,463	42,929	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07952	OTHER NONREIMBURSABLE COST CENTERS	223	15,574	15,797	0	0
194.01	07951	MEDICAL OFFICE BUILDING 1	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)	10,166,243	1,000,474	7,081,059	8,481,002	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	55.341551	14.166605	27.842888	0.273697	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				14,474	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000467	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0307

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

Worksheet B-1

Date/Time Prepared:
5/29/2019 10:23 am

Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	68,262,299				5.00
7.00	00700	OPERATION OF PLANT	4,066,577	194,859			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	271,041	0	381,420		8.00
9.00	00900	HOUSEKEEPING	1,707,796	5,398	0	189,461	9.00
10.00	01000	DIETARY	1,484,602	4,448	0	4,448	45,837
11.00	01100	CAFETERIA	30,086	1,536	0	1,536	0
13.00	01300	NURSING ADMINISTRATION	1,886,826	798	0	798	0
14.00	01400	CENTRAL SERVICES & SUPPLY	958,703	3,011	0	3,011	0
15.00	01500	PHARMACY	2,142,977	2,669	0	2,669	0
16.00	01600	MEDICAL RECORDS & LIBRARY	372,147	599	0	599	0
17.00	01700	SOCIAL SERVICE	315,315	105	0	105	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,453,371	48,315	162,406	48,315	42,870
31.00	03100	INTENSIVE CARE UNIT	1,828,210	4,821	13,479	4,821	2,967
43.00	04300	NURSERY	2,629,291	1,592	29,163	1,592	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,554,712	17,833	42,319	17,833	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	352,177	1,618	0	1,618	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,431,690	18,952	59,568	18,952	0
57.00	05700	CT SCAN	448,472	1,045	0	1,045	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	270,545	1,080	0	1,080	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	7,175,446	3,803	0	3,803	0
65.00	06500	RESPIRATORY THERAPY	1,393,170	1,254	0	1,254	0
66.00	06600	PHYSICAL THERAPY	1,547,675	8,091	0	8,091	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,738,823	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,188,890	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	2,039,786	0	0	0	0
74.00	07400	RENAL DIALYSIS	245,400	125	0	125	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	5,563,445	8,631	74,485	8,631	0
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)	65,097,173	135,724	381,420	130,326	45,837
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	34,023	409	0	409	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,110,836	42,929	0	42,929	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07952	OTHER NONREIMBURSABLE COST CENTERS	673,213	15,797	0	15,797	0
194.01	07951	MEDICAL OFFICE BUILDING 1	347,054	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)	18,480,431	5,167,509	344,419	2,313,293	2,058,790
203.00		Unit cost multiplier (Wkst. B, Part I)	0.270727	26.519222	0.902991	12.209864	44.915461
204.00		Cost to be allocated (per Wkst. B, Part II)	3,309,099	1,666,622	13,156	578,368	493,812
205.00		Unit cost multiplier (Wkst. B, Part II)	0.048476	8.552964	0.034492	3.052702	10.773218
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0307

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

Worksheet B-1
Date/Time Prepared:
5/29/2019 10:23 am

Cost Center Description		CAFETERIA (EMPLOYEE HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	801,396					11.00
13.00	01300	31,738	340,422				13.00
14.00	01400	9,799	0	4,927,713			14.00
15.00	01500	33,904	0	0	2,039,786		15.00
16.00	01600	8,030	0	0	0	333,575,351	16.00
17.00	01700	7,668	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	242,495	130,432	0	0	43,845,406	30.00
31.00	03100	28,413	23,928	0	0	4,990,304	31.00
43.00	04300	48,588	48,588	0	0	5,613,622	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	78,547	58,014	0	0	30,382,214	50.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	10,847,685	53.00
54.00	05400	87,530	10,796	0	0	54,954,239	54.00
57.00	05700	10,213	41	0	0	43,025,960	57.00
58.00	05800	3,811	0	0	0	7,601,240	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	44,653	0	0	0	53,944,693	60.00
65.00	06500	30,259	0	0	0	11,767,858	65.00
66.00	06600	27,050	0	0	0	6,173,311	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	2,738,823	0	4,545,996	71.00
72.00	07200	0	0	2,188,890	0	3,894,749	72.00
73.00	07300	0	0	0	2,039,786	23,904,044	73.00
74.00	07400	0	0	0	0	589,970	74.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	108,698	68,623	0	0	27,494,060	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		801,396	340,422	4,927,713	2,039,786	333,575,351	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
193.00	19300	0	0	0	0	0	193.00
194.00	07952	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00							201.00
202.00		97,719	2,432,416	1,336,058	2,830,641	497,075	202.00
203.00		0.121936	7.145296	0.271131	1.387715	0.001490	203.00
204.00		147,106	170,264	332,766	360,268	75,531	204.00
205.00		0.079813	0.500156	0.067530	0.176620	0.000226	205.00
206.00							206.00
207.00							207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0307

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

Worksheet B-1
Date/Time Prepared:
5/29/2019 10:23 am

Cost Center Description		SOCIAL SERVICE (PATIENT DAYS) 17.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT	1.01
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
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	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)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
193.00	19300	NONPAID WORKERS	193.00
194.00	07952	OTHER NONREIMBURSABLE COST CENTERS	194.00
194.01	07951	MEDICAL OFFICE BUILDING 1	194.01
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0307

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2019 10:23 am

		Title XVIII		Hospital		PPS		
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
				Total Costs	RCE Disallowance	Total Costs		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	21,174,488		21,174,488	0	21,174,488	30.00
31.00	03100	INTENSIVE CARE UNIT	2,863,437		2,863,437	0	2,863,437	31.00
43.00	04300	NURSERY	3,790,567		3,790,567	0	3,790,567	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,256,767		8,256,767	0	8,256,767	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	526,348		526,348	0	526,348	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,859,720		7,859,720	70,204	7,929,924	54.00
57.00	05700	CT SCAN	676,004		676,004	0	676,004	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	397,408		397,408	0	397,408	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	9,351,143		9,351,143	10,664	9,361,807	60.00
65.00	06500	RESPIRATORY THERAPY	1,840,129	0	1,840,129	0	1,840,129	65.00
66.00	06600	PHYSICAL THERAPY	2,292,525	0	2,292,525	0	2,292,525	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,229,652		4,229,652	0	4,229,652	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,380,761		3,380,761	0	3,380,761	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,458,269		5,458,269	0	5,458,269	73.00
74.00	07400	RENAL DIALYSIS	317,556		317,556	0	317,556	74.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	8,015,701		8,015,701	0	8,015,701	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,806,773		1,806,773	0	1,806,773	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	82,237,248	0	82,237,248	80,868	82,318,116	200.00
201.00		Less Observation Beds	1,806,773		1,806,773		1,806,773	201.00
202.00		Total (see instructions)	80,430,475	0	80,430,475	80,868	80,511,343	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0307

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2019 10:23 am

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	41,044,579		41,044,579		30.00
31.00	03100	INTENSIVE CARE UNIT	4,990,304		4,990,304		31.00
43.00	04300	NURSERY	5,613,622		5,613,622		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,953,799	25,428,415	30,382,214	0.271763	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	6,511,512	4,336,173	10,847,685	0.048522	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,383,835	42,570,404	54,954,239	0.143023	54.00
57.00	05700	CT SCAN	7,090,296	35,935,664	43,025,960	0.015712	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	786,946	6,814,294	7,601,240	0.052282	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	19,351,097	34,593,596	53,944,693	0.173347	60.00
65.00	06500	RESPIRATORY THERAPY	9,577,878	2,189,980	11,767,858	0.156369	65.00
66.00	06600	PHYSICAL THERAPY	1,577,409	4,595,902	6,173,311	0.371361	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	876,818	3,669,178	4,545,996	0.930413	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,351,166	2,543,583	3,894,749	0.868031	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,608,109	7,295,935	23,904,044	0.228341	73.00
74.00	07400	RENAL DIALYSIS	548,479	41,491	589,970	0.538258	74.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	4,055,660	23,438,400	27,494,060	0.291543	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	285,930	2,514,897	2,800,827	0.645086	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	137,607,439	195,967,912	333,575,351		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	137,607,439	195,967,912	333,575,351		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0307	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/29/2019 10:23 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.271763		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.048522		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.144300		54.00
57.00	05700 CT SCAN	0.015712		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.052282		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.173545		60.00
65.00	06500 RESPIRATORY THERAPY	0.156369		65.00
66.00	06600 PHYSICAL THERAPY	0.371361		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
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.930413		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.868031		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.228341		73.00
74.00	07400 RENAL DIALYSIS	0.538258		74.00
	OUTPATIENT SERVICE COST CENTERS			
91.00	09100 EMERGENCY	0.291543		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.645086		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: 14-0307

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2019 10:23 am

		Title XIX		Hospital		Cost		
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
				Total Costs	RCE Disallowance	Total Costs		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	21,174,488		21,174,488	0	21,174,488	30.00
31.00	03100	INTENSIVE CARE UNIT	2,863,437		2,863,437	0	2,863,437	31.00
43.00	04300	NURSERY	3,790,567		3,790,567	0	3,790,567	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,256,767		8,256,767	0	8,256,767	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	526,348		526,348	0	526,348	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,859,720		7,859,720	70,204	7,929,924	54.00
57.00	05700	CT SCAN	676,004		676,004	0	676,004	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	397,408		397,408	0	397,408	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	9,351,143		9,351,143	10,664	9,361,807	60.00
65.00	06500	RESPIRATORY THERAPY	1,840,129	0	1,840,129	0	1,840,129	65.00
66.00	06600	PHYSICAL THERAPY	2,292,525	0	2,292,525	0	2,292,525	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,229,652		4,229,652	0	4,229,652	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,380,761		3,380,761	0	3,380,761	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,458,269		5,458,269	0	5,458,269	73.00
74.00	07400	RENAL DIALYSIS	317,556		317,556	0	317,556	74.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	8,015,701		8,015,701	0	8,015,701	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,806,773		1,806,773	0	1,806,773	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	82,237,248	0	82,237,248	80,868	82,318,116	200.00
201.00		Less Observation Beds	1,806,773		1,806,773		1,806,773	201.00
202.00		Total (see instructions)	80,430,475	0	80,430,475	80,868	80,511,343	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0307

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2019 10:23 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	41,044,579		41,044,579		30.00
31.00	03100	INTENSIVE CARE UNIT	4,990,304		4,990,304		31.00
43.00	04300	NURSERY	5,613,622		5,613,622		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,953,799	25,428,415	30,382,214	0.271763	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	6,511,512	4,336,173	10,847,685	0.048522	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,383,835	42,570,404	54,954,239	0.143023	54.00
57.00	05700	CT SCAN	7,090,296	35,935,664	43,025,960	0.015712	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	786,946	6,814,294	7,601,240	0.052282	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	19,351,097	34,593,596	53,944,693	0.173347	60.00
65.00	06500	RESPIRATORY THERAPY	9,577,878	2,189,980	11,767,858	0.156369	65.00
66.00	06600	PHYSICAL THERAPY	1,577,409	4,595,902	6,173,311	0.371361	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	876,818	3,669,178	4,545,996	0.930413	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,351,166	2,543,583	3,894,749	0.868031	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,608,109	7,295,935	23,904,044	0.228341	73.00
74.00	07400	RENAL DIALYSIS	548,479	41,491	589,970	0.538258	74.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	4,055,660	23,438,400	27,494,060	0.291543	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	285,930	2,514,897	2,800,827	0.645086	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	137,607,439	195,967,912	333,575,351		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	137,607,439	195,967,912	333,575,351		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0307	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/29/2019 10:23 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital
		11.00		Cost
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
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
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (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
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	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
OUTPATIENT SERVICE COST CENTERS				
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: 14-0307		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part I Date/Time Prepared: 5/29/2019 10:23 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)	Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	5,772,820	0	5,772,820	15,165	380.67	30.00
31.00	INTENSIVE CARE UNIT	595,590		595,590	989	602.21	31.00
43.00	NURSERY	309,599		309,599	2,934	105.52	43.00
200.00	Total (lines 30 through 199)	6,678,009		6,678,009	19,088		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	5,294	2,015,267				
31.00	INTENSIVE CARE UNIT	514	309,536				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	5,808	2,324,803				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0307	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Prepared: 5/29/2019 10:23 am
Title XVIII			Hospital	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	2,004,625	30,382,214	0.065980	1,959,818	129,309	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	172,895	10,847,685	0.015938	404,989	6,455	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,799,524	54,954,239	0.032746	6,055,165	198,282	54.00
57.00	05700 CT SCAN	131,496	43,025,960	0.003056	3,790,610	11,584	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	117,576	7,601,240	0.015468	394,771	6,106	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	668,311	53,944,693	0.012389	8,339,949	103,324	60.00
65.00	06500 RESPIRATORY THERAPY	191,894	11,767,858	0.016307	5,047,515	82,310	65.00
66.00	06600 PHYSICAL THERAPY	539,613	6,173,311	0.087411	869,363	75,992	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	318,744	4,545,996	0.070115	320,822	22,494	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	254,805	3,894,749	0.065423	126,451	8,273	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	464,551	23,904,044	0.019434	6,559,662	127,480	73.00
74.00	07400 RENAL DIALYSIS	23,878	589,970	0.040473	382,645	15,487	74.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	1,141,312	27,494,060	0.041511	1,954,797	81,146	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	492,582	2,800,827	0.175870	215,235	37,853	92.00
200.00	Total (lines 50 through 199)	8,321,806	281,926,846		36,421,792	906,095	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0307	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part III Date/Time Prepared: 5/29/2019 10:23 am
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Cost Center Description		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
		1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	200.00
Cost Center Description		Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days	
		4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	15,165	0.00	5,294	30.00
31.00	03100	INTENSIVE CARE UNIT		989	0.00	514	31.00
43.00	04300	NURSERY		2,934	0.00	0	43.00
200.00		Total (lines 30 through 199)		19,088		5,808	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
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: 14-0307	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 10:23 am
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Cost Center Description	Title XVIII				Hospital		PPS
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
	1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	0	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
57.00 05700 CT SCAN	0	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
91.00 09100 EMERGENCY	0	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00 Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0307

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2019 10:23 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	30,382,214	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	10,847,685	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54,954,239	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	43,025,960	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	7,601,240	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	53,944,693	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,767,858	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,173,311	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,545,996	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,894,749	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	23,904,044	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	589,970	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	27,494,060	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,800,827	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	281,926,846		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0307	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 10:23 am
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Cost Center Description		Title XVIII				Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	0.000000	1,959,818	0	4,811,640	0	50.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00	
53.00	05300 ANESTHESIOLOGY	0.000000	404,989	0	659,492	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	6,055,165	0	10,347,673	0	54.00	
57.00	05700 CT SCAN	0.000000	3,790,610	0	8,406,770	0	57.00	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	394,771	0	1,853,779	0	58.00	
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00	
60.00	06000 LABORATORY	0.000000	8,339,949	0	4,409,226	0	60.00	
65.00	06500 RESPIRATORY THERAPY	0.000000	5,047,515	0	603,514	0	65.00	
66.00	06600 PHYSICAL THERAPY	0.000000	869,363	0	35,146	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	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	320,822	0	454,034	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	126,451	0	6,399	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	6,559,662	0	1,597,435	0	73.00	
74.00	07400 RENAL DIALYSIS	0.000000	382,645	0	14,184	0	74.00	
OUTPATIENT SERVICE COST CENTERS								
91.00	09100 EMERGENCY	0.000000	1,954,797	0	4,152,953	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	215,235	0	732,639	0	92.00	
200.00	Total (lines 50 through 199)		36,421,792	0	38,084,884	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0307	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/29/2019 10:23 am
Title XVIII		Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.271763	4,811,640	0	0	1,307,626	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.048522	659,492	0	0	32,000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.143023	10,347,673	0	9,931	1,479,955	54.00
57.00	05700 CT SCAN	0.015712	8,406,770	0	9,310	132,087	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.052282	1,853,779	0	2,483	96,919	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.173347	4,409,226	0	0	764,326	60.00
65.00	06500 RESPIRATORY THERAPY	0.156369	603,514	0	0	94,371	65.00
66.00	06600 PHYSICAL THERAPY	0.371361	35,146	0	0	13,052	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
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.930413	454,034	0	0	422,439	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.868031	6,399	0	0	5,555	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.228341	1,597,435	0	40,344	364,760	73.00
74.00	07400 RENAL DIALYSIS	0.538258	14,184	0	0	7,635	74.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0.291543	4,152,953	0	0	1,210,764	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.645086	732,639	0	0	472,615	92.00
200.00	Subtotal (see instructions)		38,084,884	0	62,068	6,404,104	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)		38,084,884	0	62,068	6,404,104	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0307	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/29/2019 10:23 am
Title XVIII		Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	1,420	54.00
57.00	05700 CT SCAN	0	146	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	130	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
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	9,212	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS				
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	10,908	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	0	10,908	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0307	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/29/2019 10:23 am
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		Title XIX		Hospital		Cost	
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	0.271763	0	577,693	0	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0.048522	0	93,233	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.143023	0	500,789	0	0 54.00
57.00	05700	CT SCAN	0.015712	0	688,579	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.052282	0	68,339	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0 59.00
60.00	06000	LABORATORY	0.173347	0	938,909	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	0.156369	0	39,680	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0.371361	0	25,274	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.930413	0	102,593	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.868031	0	62,630	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.228341	0	138,448	0	0 73.00
74.00	07400	RENAL DIALYSIS	0.538258	0	0	0	0 74.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.291543	0	863,716	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.645086	0	0	0	0 92.00
200.00		Subtotal (see instructions)		0	4,099,883	0	0 200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0 201.00
202.00		Net Charges (line 200 - line 201)		0	4,099,883	0	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0307	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/29/2019 10:23 am
	Title XIX	Hospital	Cost

Cost Center Description	Costs			Cost	
	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	156,996	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	4,524	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	71,624	0	54.00
57.00	05700	CT SCAN	10,819	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,573	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	162,757	0	60.00
65.00	06500	RESPIRATORY THERAPY	6,205	0	65.00
66.00	06600	PHYSICAL THERAPY	9,386	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	95,454	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	54,365	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,613	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	251,810	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	859,126	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	859,126	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0307	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/29/2019 10:23 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		15,165	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		15,165	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)		13,871	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)		5,294	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)		21,174,488	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)		21,174,488	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)		21,174,488	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,396.27	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		7,391,853	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)		7,391,853	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0307		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1	
Date/Time Prepared: 5/29/2019 10:23 am		Title XVIII		Hospital		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	2,863,437	989	2,895.29	514	1,488,179		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)					6,886,507		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					15,766,539		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					2,324,803		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					906,095		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					3,230,898		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					12,535,641		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					1,294		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,396.27		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,806,773		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0307		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/29/2019 10:23 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	5,772,820	21,174,488	0.272631	1,806,773	492,582	90.00
91.00	Nursing School cost	0	21,174,488	0.000000	1,806,773	0	91.00
92.00	Allied health cost	0	21,174,488	0.000000	1,806,773	0	92.00
93.00	All other Medical Education	0	21,174,488	0.000000	1,806,773	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0307	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/29/2019 10:23 am
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		15,165	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		15,165	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.		2,338	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		11,533	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,118	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)		2,934	15.00
16.00	Nursery days (title V or XIX only)		1,280	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)		21,174,488	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)		21,174,488	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		5,386,752	28.00
29.00	Private room charges (excluding swing-bed charges)		5,386,752	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)		3.930845	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		2,304.00	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)		2,304.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		9,056.67	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		21,174,494	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		-6	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)		0.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		0	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)		0	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0307		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1	
Date/Time Prepared: 5/29/2019 10:23 am		Title XIX		Hospital		Cost	
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)	3,790,567	2,934	1,291.95	1,280	1,653,696		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	2,863,437	989	2,895.29	83	240,309		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)					556,226		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,450,231		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)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge						0.00	55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						1,294	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,396.27	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						1,806,773	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0307		Period: From 01/01/2018 To 12/31/2018		Worksheet D-1 Date/Time Prepared: 5/29/2019 10:23 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	5,772,820	21,174,488	0.272631	1,806,773	492,582	90.00
91.00	Nursing School cost	0	21,174,488	0.000000	1,806,773	0	91.00
92.00	Allied health cost	0	21,174,488	0.000000	1,806,773	0	92.00
93.00	All other Medical Education	0	21,174,488	0.000000	1,806,773	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0307	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/29/2019 10:23 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		13,232,454		30.00
31.00	03100 INTENSIVE CARE UNIT		2,595,197		31.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.271763	1,959,818	532,606	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.048522	404,989	19,651	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.144300	6,055,165	873,760	54.00
57.00	05700 CT SCAN	0.015712	3,790,610	59,558	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.052282	394,771	20,639	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.173545	8,339,949	1,447,356	60.00
65.00	06500 RESPIRATORY THERAPY	0.156369	5,047,515	789,275	65.00
66.00	06600 PHYSICAL THERAPY	0.371361	869,363	322,848	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.930413	320,822	298,497	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.868031	126,451	109,763	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.228341	6,559,662	1,497,840	73.00
74.00	07400 RENAL DIALYSIS	0.538258	382,645	205,962	74.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.291543	1,954,797	569,907	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.645086	215,235	138,845	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		36,421,792	6,886,507	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)		36,421,792		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0307	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/29/2019 10:23 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		1,600,484		30.00
31.00	03100 INTENSIVE CARE UNIT		80,816		31.00
43.00	04300 NURSERY		1,692,834		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.271763	130,574	35,485	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.048522	518,110	25,140	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.143023	228,451	32,674	54.00
57.00	05700 CT SCAN	0.015712	211,698	3,326	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.052282	35,428	1,852	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.173347	817,247	141,667	60.00
65.00	06500 RESPIRATORY THERAPY	0.156369	183,299	28,662	65.00
66.00	06600 PHYSICAL THERAPY	0.371361	41,637	15,462	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.930413	16,049	14,932	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.868031	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.228341	965,685	220,505	73.00
74.00	07400 RENAL DIALYSIS	0.538258	18,912	10,180	74.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.291543	90,351	26,341	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.645086	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		3,257,441	556,226	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)		3,257,441		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0307	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/29/2019 10:23 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)		7,443,056	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		2,388,941	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)		798,377	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		3,651,064	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		90.45	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)		2.25	30.00
31.00	Percentage of Medicaid patient days (see instructions)		24.49	31.00
32.00	Sum of lines 30 and 31		26.74	32.00
33.00	Allowable disproportionate share percentage (see instructions)		11.28	33.00
34.00	Disproportionate share adjustment (see instructions)		277,262	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0307	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/29/2019 10:23 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)	0.000061027	0.000061027	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	412,951	504,869	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	308,865	127,255	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	436,120		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)	11,343,756		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)		11,343,756	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,746,263	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		14,090,019	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		14,090,019	61.00
62.00	Deductibles billed to program beneficiaries		1,285,848	62.00
63.00	Coinurance billed to program beneficiaries		27,470	63.00
64.00	Allowable bad debts (see instructions)		176,948	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		115,016	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		175,608	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		12,891,717	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)		33,816	70.93
70.94	HRR adjustment amount (see instructions)		-11,467	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0307	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/29/2019 10:23 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	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		12,914,066	71.00
71.01	Sequestration adjustment (see instructions)		258,281	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		12,485,567	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)		170,218	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		690,963	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
			Prior to 10/1	On/After 10/1
			1.00	2.00
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0307

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/29/2019 10:23 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	7,443,056	0	7,443,056		7,443,056	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,388,941	0		2,388,941	2,388,941	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	798,377	0	635,322	163,055	798,377	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	3,651,064	0	2,730,795	920,269	3,651,064	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	0.1128	0.1128	0.1128	0.1128		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	277,262	0	209,894	67,368	277,262	11.00
11.01	Uncompensated care payments	36.00	436,120	0	308,865	127,255	436,120	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	11,343,756	0	8,597,137	2,746,619	11,343,756	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	11,343,756	0	8,597,137	2,746,619	11,343,756	15.00
16.00	Payment for inpatient program capital (From Wkst. L, Pt. I, if applicable)	50.00	0	0	0	0	0	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ acquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0307

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/29/2019 10:23 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	8,597,137	2,746,619	11,343,756	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	0	0	-193,020	193,020	0	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	0	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	0	0	-193,020	193,020	0	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				0.180357	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			1,550,554		1,550,554	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.		N					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 14-0307		Period: From 01/01/2018 To 12/31/2018		Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/29/2019 10:23 am	
		Title XVIII		Hospital		PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (col. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	7,443,056	7,443,056		7,443,056	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,388,941		2,388,941	2,388,941	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	798,377	635,322	163,055	798,377	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	3,651,064	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	0.1128	0.1128	0.1128		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	277,262	209,894	67,368	277,262	11.00
11.01	Uncompensated care payments	36.00	436,120	308,865	127,255	436,120	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	11,343,756	8,597,137	2,746,619	11,343,756	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	11,343,756	8,597,137	2,746,619	11,343,756	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	0	0	0	0	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			8,597,137	2,746,619	11,343,756	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	0	-193,020	193,020	0	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	0	0	0	0	21.00	
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01	
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00	
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00	
26.00	Total prospective capital payments (see instructions)	12.00	0	-193,020	193,020	0	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	33,816	0	33,816	33,816	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	-11,467	0	-11,467	-11,467	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: 14-0307	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/29/2019 10:23 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		10,908	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		6,404,104	2.00
3.00	OPPS payments		4,558,494	3.00
4.00	Outlier payment (see instructions)		13,921	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)		10,908	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		62,068	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)		62,068	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)		62,068	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		51,160	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)		10,908	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)		4,572,415	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)		934,410	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)		3,648,913	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)		3,648,913	30.00
31.00	Primary payer payments		2,768	31.00
32.00	Subtotal (line 30 minus line 31)		3,646,145	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)		89,819	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		58,382	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		89,652	36.00
37.00	Subtotal (see instructions)		3,704,527	37.00
38.00	MSP-LCC reconciliation amount from PS&R		28	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)		3,704,499	40.00
40.01	Sequestration adjustment (see instructions)		74,090	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		3,575,686	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		54,723	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: 14-0307

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

Worksheet E-1
Part I
Date/Time Prepared:
5/29/2019 10:23 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		12,691,343		3,575,686	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	08/06/2018	205,776		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)		-205,776		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)		12,485,567		3,575,686	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		170,218		54,723	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		12,655,785		3,630,409	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: 14-0307	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/29/2019 10:23 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

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

Provider CCN: 14-0307

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

Worksheet G

Date/Time Prepared:
5/29/2019 10:23 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	-14,309,785	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	32,434,792	0	0	0	4.00
5.00	Other receivable	1,306,220	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-21,800,461	0	0	0	6.00
7.00	Inventory	1,234,742	0	0	0	7.00
8.00	Prepaid expenses	444,097	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)	-690,395	0	0	0	11.00
FIXED ASSETS						
12.00	Land	9,200,000	0	0	0	12.00
13.00	Land improvements	5,433,065	0	0	0	13.00
14.00	Accumulated depreciation	-1,471,784	0	0	0	14.00
15.00	Buildings	99,292,151	0	0	0	15.00
16.00	Accumulated depreciation	-16,447,561	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	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	27,401,758	0	0	0	23.00
24.00	Accumulated depreciation	-14,901,581	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	24,782,484	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	133,288,532	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,755,107	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,755,107	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	134,353,244	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	918,487	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,354,208	0	0	0	38.00
39.00	Payroll taxes payable	0	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	36,980,415	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	41,253,110	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	158,400,000	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	784,368	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	159,184,368	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	200,437,478	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-66,084,234				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-66,084,234	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	134,353,244	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0307

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

Worksheet G-1

Date/Time Prepared:
5/29/2019 10:23 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		-49,110,375		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-18,964,694			2.00
3.00	Total (sum of line 1 and line 2)		-68,075,069		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		-68,075,069		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-68,075,069		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	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0307

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/29/2019 10:23 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	46,034,160		46,034,160	1.00
2.00	SUBPROVIDER - IPF				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)	46,034,160		46,034,160	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,003,183		5,003,183	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)	5,003,183		5,003,183	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	51,037,343		51,037,343	17.00
18.00	Ancillary services	85,648,011	169,960,600	255,608,611	18.00
19.00	Outpatient services	3,410,845	23,518,552	26,929,397	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	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	140,096,199	193,479,152	333,575,351	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		91,671,129		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		91,671,129		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0307

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

Worksheet G-3

Date/Time Prepared:
5/29/2019 10:23 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	333,575,351	1.00
2.00	Less contractual allowances and discounts on patients' accounts	257,235,726	2.00
3.00	Net patient revenues (line 1 minus line 2)	76,339,625	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	91,671,129	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-15,331,504	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	339,279	6.00
7.00	Income from investments	199	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	195,671	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	4	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	28,697	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	1,025,920	22.00
23.00	Governmental appropriations	0	23.00
24.00	MEDICAID HIT	0	24.00
24.01	MEDICARE HIT	0	24.01
24.02	BJC OTHER OPERATING REVENUE	127,018	24.02
25.00	Total other income (sum of lines 6-24)	1,716,788	25.00
26.00	Total (line 5 plus line 25)	-13,614,716	26.00
27.00	PHYSICIAN PRACTICE OPERATIONS	3,749,204	27.00
27.01	PHYSICIAN OFFICE BUILDING	1,600,774	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	5,349,978	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-18,964,694	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0307	Period: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III Date/Time Prepared: 5/29/2019 10:23 am
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			0 1.00
1.01	Model 4 BPCI Capital DRG other than outlier			0 1.01
2.00	Capital DRG outlier payments			0 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)		0.00	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		0	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		2,324,803	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		906,095	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		3,230,898	3.00
4.00	Capital cost payment factor (see instructions)		85	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		2,746,263	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